

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER MANHATTAN COMMUNITY CARE CENTER				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	
M0000	Initial Comments The State Agency (SA) conducted an Annual Recertification along with three (3) Complaint Investigations (CI MS #3159872, CI MS #3157993, and CI MS #3107443) at the facility from 8/17/26 to 8/20/26. CI MS #3159872 was investigated for quality of care/treatment. CI MS #3157993 was investigated for resident/patient/client rights, nursing services and CI MS #3107443 was investigated for quality of care/treatment, admission/transfer rights, nursing services, resident/patient/client rights. There were no citations related to the CIs. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M620 and M1570.		M0000				
M0620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident 's clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and policy review the facility failed to provide appropriate treatment and services during incontinent care, as evidenced by failure to fully clean the perineal area and only cleaning the buttocks area for one (1) of seven (7) care observations. Resident #12. Findings Include: Record review of the facility's "Perineal Care "with a revision date of 2/2018 revealed, "The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infection and skin irritation and to observe the resident skin condition. Steps in the procedure: For a female resident. Clean the perineal area using a fresh wipe for each downward cleaning motion from front to back Ensure the labia is open for thorough cleaning. Clean the buttocks perineum thoroughly, moving from		M0620				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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M0620	Continued from page 1 inside outwards to the thighs...Remove gloves perform hand hygiene and replace them with clean set of gloves. Place a clean brief on the resident..." On 08/17/2026 at 3:15 PM, observed Resident #12 in bed watching tv. There was a foul smell of urine in the room. On 08/19/2026 at 9:09 AM, an observation of Resident #12 receiving peri care by Certified Nursing Assistant (CNA) #4 and assisted by CNA #5. CNA #4 did not perform hand hygiene upon entry. She applied clean gloves and removed the brief and turned resident on her left side. Resident #12 had feces in the brief and a protective dressing on the sacrum. CNA #4 wiped front to back and back to front several times. She stated that she will inform the nurse the dressing needs to be changed. After cleaning the buttocks, she placed a clean brief under the resident and turned her over and fastened the brief with dirty gloves on. On 08/19/2026 at 9:20 AM, an interview with CNA #5 confirmed that CNA #4 did not complete peri care. She stated CNA #4 wiped the buttocks front to back and back to front several times. She stated CNA #4 did not do peri care in the front. She stated the resident was placed at risk for infection. On 08/19/2026 at 9:25 AM, an interview with CNA #4 confirmed that she did not provide care in the vaginal area and wiped back to front and front to back. She stated Resident#12 could get an infection or urinary tract infection (UTI) when care is not done correctly. On 08/19/26 at 3:55PM, in an interview the Director of Nursing (DON) stated that CNA #4 should have provided peri care by wiping front to back only. She stated peri care should have been done in the vaginal area as well. She stated not doing it completely can cause Resident #12 to get an infection or UTI. She stated she expects CNAs to use the clean technique and the inside out technique doing peri care. On 08/20/2026 10:09 AM in an interview with Licensed Practical Nurse (LPN) #3/Infection Preventionist (IP) stated CNA #4 should have started in the front. CNA#4 should wipe front to back and clean the vaginal area. She stated CNA #4 should not have touched clean brief and bed linens with dirty gloves on. She stated Resident #12 could get an infection from care she received. On 08/20/2026 at 10:26 AM, in an interview with the	M0620					

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M0620	Continued from page 2 Assistant Director of Nursing (ADON) stated CNA #4 should have wiped from front to back. CNA#4 should have started care in the front. She stated CNA#4 exposed Resident #12 to UTI, and bacterial infection. She stated her expectations are for CNAs to care for residents as if they have their own family. She stated she expects staff to take pride in their work and treat residents with respect. Record review of Resident #12's "Admission Record" revealed an admission date of 7/18/25 with diagnoses that included Unspecified Dementia, unspecified severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety. Record review of Resident #12's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/19/26 revealed a Brief Interview for Mental Status (BIMS) score of 09 which indicates the resident had moderate cognitive impairment.		M0620				
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by:		M1570				

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M1570	Continued from page 3 Based on observation, interview, record review and facility policy review the facility failed to follow infection prevention guidelines for two (2) of seven (7) residents observed during medication administration and care observations. Resident #12 and Resident #138. Findings Include: Record review of the facility policy "Handwashing/Hand Hygiene" with a revision date of 8/2015 revealed the facility considers hand hygiene the primary, means to prevent the spread of infections. before and after contact with residents, before moving from a contaminated body site to a clean body site during resident care and after removing gloves. Record review of the facility policy "Infection Prevention" revised April 2019 revealed, "Staff follows established facility infection control procedures (E.g. handwashing, antiseptic technique, gloves, isolation precautions, etc. for the administration of medications, as applicable..." Resident #12 On 08/17/26 at 3:15 PM, Resident #12 was observed in bed watching television. A foul odor of urine was present in the resident's room. On 08/19/26 at 9:09 AM, an observation revealed Certified Nursing Assistant (CNA) #4, assisted by CNA #5, provided perineal care to Resident #12. CNA #4 did not perform hand hygiene upon entering the room. CNA #4 applied gloves, removed the resident's soiled brief, and turned the resident onto the left side. CNA #4 did not change gloves or perform hand hygiene during the care. CNA #4 touched the clean brief and bed linens with the same gloves used during the contaminated portion of the care. CNA #4 did not perform hand hygiene after completing the care. During an interview on 08/19/26 at 9:20 AM, CNA #5 confirmed CNA #4 did not perform hand hygiene throughout the perineal care. CNA #5 stated the failure placed Resident #12 at risk for infection. During an interview on 08/19/26 at 9:25 AM, CNA #4 confirmed she did not perform hand hygiene or change gloves during the care. CNA #4 stated Resident #12 could develop an infection or urinary tract infection when perineal care was not performed correctly.		M1570				

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M1570	Continued from page 4 During an interview on 08/19/26 at 3:55 PM, the Director of Nursing (DON) stated CNA #4 should have performed hand hygiene upon entering the room, during care when her hands became contaminated, and upon leaving the room. The DON stated the failure to perform hand hygiene could cause Resident #12 to develop an infection or urinary tract infection. The DON stated she expected CNAs to use clean technique and an inside-out technique when providing perineal care. During an interview on 08/20/26 at 10:09 AM, Licensed Practical Nurse (LPN) #3, the facility's Infection Preventionist (IP), stated CNA #4 should have performed hand hygiene upon entering the room, during care, and after completing care. LPN #3 stated CNA #4 should have changed gloves and performed hand hygiene during the care and should not have touched the clean brief or bed linens with contaminated gloves. LPN #3 stated Resident #12 could develop an infection because of the care provided. During an interview on 08/20/26 at 10:26 AM, the Assistant Director of Nursing (ADON) stated CNA #4 should have performed hand hygiene upon entering the room, changed gloves and performed hand hygiene during the care, and performed hand hygiene after completing the care. The ADON stated CNA #4 exposed Resident #12 to the risk of a urinary tract infection or bacterial infection. Record review of Resident #12's "Admission Record" revealed an admission date of 07/18/25 with diagnoses that included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety. Record review of Resident #12's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/19/26, revealed a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. Resident #138 On 08/19/26 at 8:59 AM, while preparing medications for Resident #138, LPN #2 used her bare, ungloved hand to remove an Acidophilus tablet. LPN #2 placed the tablet into a medication cup with the resident's other morning medications. LPN #2 then administered the medications to Resident #138, who ingested them. During an interview immediately following the observation, LPN #2 confirmed she touched the	M1570					

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M1570	Continued from page 5 medication with her bare hand. LPN #2 stated nurses should avoid touching medications or anything a resident might ingest with their bare hands because pathogens could be transmitted to the resident. LPN #2 stated failure to follow medication administration and infection prevention practices could increase the resident's risk for infection. During an interview on 08/19/26 at 3:37 PM, LPN #3, the facility's IP, stated nurses should never touch medications with their bare hands. LPN #3 stated touching medications with bare hands could expose residents to pathogens, even if hand hygiene was performed before medication administration. LPN #3 stated she expected staff to follow the facility's infection prevention practices when caring for residents. During an interview on 08/19/26 at 3:58 PM, the DON stated nurses should avoid touching medications with their bare hands to prevent transmitting pathogens to residents. The DON stated she expected staff to follow infection prevention practices during medication administration. The DON stated failure to follow infection prevention practices increased residents' risk for infection. Record review of Resident #138's "Admission Record" revealed the facility admitted the resident on 07/13/26 with diagnoses that included hemiplegia and hemiparesis. Record review of Resident #138's "Order Summary" revealed an order for Acidophilus Probiotic Oral Tablet, Lactobacillus, one tablet by mouth once daily for irritable bowel syndrome, with a start date of 07/14/26. Record review of Resident #138's Medication Administration Record revealed Acidophilus was documented as administered at 9:00 AM on 08/19/26. Record review of Resident #138's MDS with an ARD of 07/13/26, revealed a BIMS score of 15, indicating the resident was cognitively intact.			M1570			