STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255335	A. BUILDING _____ B. WING _____	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST GENERAL HOSPITAL SKILLED NURSING UNIT	6051 US HIGHWAY 49 SOUTH HATTIESBURG, MS 39401

(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 an Annual Recertification Survey at the facility from 5/5/25 through 5/7/25. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F880. The facility was licensed for 30 beds and had a census of 28.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		5/27/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/16/2025

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 880	Continued From page 1 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to follow appropriate infection prevention practices by not ensuring oxygen tubing was stored in a clean and sanitary manner when not in use for one (1) of two (2) residents reviewed for oxygen therapy, Resident #140. Findings Included: On 05/05/25 at 11:29 AM, during an observation and interview, Resident #140 was lying in bed. There was a nasal cannula (NC) and oxygen tubing wrapped around the side rail. Resident #140 stated that she usually wears oxygen at night, and sometimes during the day if she needs it. She confirmed that she had wrapped the NC and oxygen tubing around the side rail because she did not want it to fall to the floor. There was no bag available to place the tubing in while it was not in use. On 05/06/25 at 10:55 AM, during an observation and interview with Registered Nurse (RN) #1, Resident #140 was observed lying in bed with the NC and oxygen tubing resting on the floor. RN #1 stated that when oxygen is not in use, the NC and tubing should be stored in a clean plastic bag and kept within reach of the resident. She confirmed there was no plastic bag available in the resident's room for proper storage and acknowledged the tubing was not stored according to infection control standards. RN #1 immediately retrieved the tubing from the floor, discarded it, and stated she would replace it with a new NC and tubing.	F 880	On May 05, 2025 the State Agency (SA) conducted an annual recertification survey and discovery that the facility failed to follow appropriate infection prevention practices by not ensuring oxygen tubing was stored in a clean and sanitary manner when not in use for one (1) of two (2) residents reviewed for oxygen therapy, resident #140. On May 05, 2025, during observation and interview with resident #140 the State Agency (SA) interviewed resident #140 and interviewed was lying in bed. The nasal cannula (NC) and oxygen tubing was around the side rail of the bed. On May 06, 2025, during a follow-up observation and interview of Registered Nurse (RN) by SA, resident #140 was observed lying in bed with the NC and oxygen tubing resting on the floor. RN #1 identified that when oxygen is not in use, the NC and tubing should be stored in a clean plastic bag and kept within reach of the resident. RN #1 immediately recognized the need for a plastic bag for proper storage and acknowledge that the tubing was not stored according to infection control standards. RN #1 immediately retrieved the tubing from the floor, discarded it and replaced it with new NC and tubing and Director of Nursing (DON) assisted with obtaining the needed drawstring plastic bags from respiratory department. This corrective intervention was done immediately by RN #1 to safeguard resident #140 regarding	

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F 880	Continued From page 3 On 05/06/25 at 11:10 AM, during an interview with the Director of Nursing (DON) and the Administrator, the DON explained that the Respiratory Therapy department provides drawstring plastic bags for residents to store their oxygen tubing when not in use. She stated the tubing should be placed in the bags and stored in a wire basket mounted on the wall above the resident's bed. The DON confirmed that Resident #140 did not have a storage bag available at the bedside and stated she would ensure one was provided. She further acknowledged that the facility did not have a specific policy addressing the storage of nasal cannulas or oxygen tubing as it relates to infection control. A record review of the facility's "Patient Information" document revealed Resident #140 was admitted by the facility on 5/1/25 with current diagnoses including Right Total Knee Arthroplasty. A record review of the "Assessment and Plan", dated 5/1/25, revealed a Physician's Order for Oxygen three (3) liters nightly and as needed.	F 880	infection prevention practices. On May 06, 2025, the Administrator and DON implemented an oxygen management policy for the Skilled Nursing Unit (SNU) to ensure that each resident receives necessary respiratory care and services that is in accordance with professional standards of practice, the residents care plan and the residents choice, as medically practicable; including proper storage of NC and tubing when not in use by resident(s). This policy is an addition to the established infection prevention and control policy that is currently in place. This addition will include using a monitoring tool to conduct real-time findings related to all residents who utilized respiratory equipment related to an oxygen order, green oxygen in use signage on door and plastic drawstring bag in place for storage when not in use for 3weeks; started on May 06, 2025 and to be completed on May 27, 2025. To protect residents in similar situations and to meet the professional standards of practice; while preventing the potential of infections and communicable disease, the use of standard precautions will be utilized regarding the implemented oxygen management policy for the SNU. Due to the potential to affect all residents related to the storage of oxygen tubing/storage of respiratory equipment, the Administrator, DON and Patient Care Coordinator (PCC) will monitor this for three (3) weeks; bi-weekly, beginning on May 06, 2025 to conduct real-time corrections related to	

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F 880	Continued From page 4	F 880	the findings related to all residents who utilized respiratory equipment related to an oxygen order, green oxygen in use signage on door and plastic drawstring bag in place for storage when not in use. The DON conducted rounding on May 06, 2025 for all the residents who utilized respiratory equipment related to an oxygen order. This will be conducted on a bi-weekly basis and to be completed on May 27, 2025. The initial rounding began on May 06, 2025 by DON, on May 09, 2025 by PCC and repeated on May 12, 2025 by DON, on May 15, 2025 by PCC and on May 19, 2025 by DON. Further rounding related to all resident who utilized respiratory equipment will conducted on May 22, 2025 by DON and on May 26, 2025 by PCC to ensure compliance regarding this finding. This monitoring by the PCC will continue weekly times three (3) months in June 2025, July 2025 and August 2025, then once a month every other month, times two (2) months in October 2025 and December 2025 to ensure complete compliance for all residents who utilize respiratory equipment. On May 06, 2025, following this observation, the SA interviewed the DON and the Administrator. DON explained that the respiratory department provides the drawstring plastic bags for the oxygen tubing when not in use. The DON acknowledged that tubing was not stored according to infection control standards and that the facility did not have a specific policy addressing the storage of NC or	

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F 880	Continued From page 5	F 880	oxygen tubing as it relates to infection control. The implementation of the oxygen management policy for the SNU will be discussed as new business during Quality Assurance (QA) meeting to be held on May 27, 2025 and will continue to be monitored for three (3) months (June 2025, July 2025 and August 2025). The oxygen management policy for the SNU will be reviewed annually by the SNU Infection Prevention and Control Program or as necessary. The monitoring observations related to residents who utilized respiratory equipment will be completed on May 27, 2025.	