

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

PRINTED: 06/17/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                          |                            |                                                        |
|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255335</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - FORREST GENERAL SKILLED<br/>NURSING UNIT</b><br>B. WING _____          |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/31/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>FORREST GENERAL HOSPITAL SKILLED NURSING UNIT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6051 US HIGHWAY 49 SOUTH<br/>HATTIESBURG, MS 39401</b>                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| K 000                                                                                    | <p>INITIAL COMMENTS</p> <p>42 CFR 483.70(a)</p> <p>This facility was surveyed under the Centers for Medicare Medicaid Services (CMS) COVID-19 Emergency Declaration Blanket 1135 Waivers for Health Care Provider. The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).</p> <p>There were no LSC deficiencies cited during this survey.</p> | K 000                                                                      |                                                                                                                          |                            |                                                        |

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

TITLE

(X6) DATE

Electronically Signed

06/15/2022

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.