STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255272	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Myrtles Nursing Center, LLC	1018 Alberta Avenue Columbia, MS 39429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews, record review, and facility policy review, the facility failed to implement its abuse prevention and investigation policy when Licensed Practical Nurse (LPN) #1 and Certified Nurse Aide (CNA) #1 witnessed Registered Nurse (RN) #1 attempting to prevent Resident #2 from bringing cigarettes into the facility and did not report the incident to the Administrator for one (1) of four (4) sampled residents (Resident #2).Findings included:A review of the facility's policy Incident Investigation & Reporting, revised 05/24, revealed, .Purpose: To provide guidance to the facility for investigation and reporting incidents.3.In the event of any incident involving an allegation or suspicion of mistreatment, exploitation, neglect, abuse.each occurrence will be reported immediately to the Administrator of the facility.A record review of the admission Record revealed the facility admitted Resident #2 on 7/3/24 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/10/25 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated he was cognitively intact.On 12/17/25 at 5:33 PM, during an interview with Resident #2, he reported that on 11/21/25 around 4:30 PM, Registered Nurse (RN #1) physically blocked him from entering the building while attempting to take a bag containing cigarettes from him. He explained that his family had brought cigarettes for him and that he was attempting to bring them inside to give to staff for storage. He described a tussle over the bag at the doorway into the facility and complained that his arm became caught while the RN continued to block him from entering the facility.On 12/18/25 at 10:30 AM, during an interview with LPN #1, she confirmed she witnessed the incident on 11/21/25 involving the disagreement between Resident #2 and RN #1. She explained that RN #1 attempted to take the bag that contained cigarettes from the resident. She reported that the resident's arm inadvertently became caught during this time. LPN #1 stated the resident ultimately handed the cigarettes to her. She confirmed she did not document the incident and did not report it to the Director of Nursing (DON), Assistant Director of Nursing (ADON), or Administrator.On 12/18/25 at 11:20 AM, RN #1 stated that on 1/21/25, she had asked Resident #1 to give her the cigarettes and he would not. She tried to reason with him and confirmed that she did block the door to keep him from entering the facility with the cigarettes. She reported that the resident tried to reach around her and that she had gotten hit by the door handle. She denied that the resident's arm got bumped. Resident #2 ultimately gave the bag to LPN #1.On 12/18/25 at 11:29 AM, during an interview with a CNA #1, she confirmed she observed the incident between Resident #2 and RN #1. She described RN #1 standing in front of the door and both RN #1 and Resident #2 pulling back and forth on the bag of cigarettes. She confirmed she did not contact facility leadership about the disagreement. On 12/18/25 at 12:55 PM, during an interview with the Director of Nursing (DON), she confirmed that staff are trained to notify leadership when an incident occurs. She explained that had she been informed of the incident, she would have initiated an investigation immediately.On 12/18/25 at 3:50 PM, during an interview with the Administrator, she confirmed she was not informed of the incident involving Resident #2 and RN #1. She explained that if she had been notified, she would have expected the incident to be investigated.