STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115615	A. Building B. Wing	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baptist Village, Inc.	2650 Carswell Ave Waycross, GA 31502

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, review of the facility documentation, and review of the facility's policy titled MDS (Minimum Data Set) - Care Plan, the facility failed to implement a person-centered, comprehensive care plan related to the administration of medication as ordered for one of nine residents (R) (R1) reviewed for a medication administration. Specifically, the facility administers Methotrexate 2.5 mg (milligram) once a day instead of once weekly, as ordered. As a result, R1 experienced medical complications requiring a transfer to an acute care hospital and expired on [DATE] due to Methotrexate toxicity.On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.The facility's Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy (IJ) on [DATE] at 4:27 pm. The noncompliance related to the IJ was identified as existing on [DATE].An Acceptable IJ Removal Plan was received on [DATE]. Based on observations, record reviews, interviews, and review of the facility's policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice were removed on [DATE] (Past Noncompliance).Findings included:A review of the clinical Electronic Medical Record (EMR) revealed that R1 was last readmitted to the facility on [DATE] with diagnoses including, but not limited to, metabolic encephalopathy, dementia, rheumatoid arthritis, hyperlipidemia, and anxiety.A review of [Named] hospital records revealed R1 had an admission date of [DATE] with chief complaint, physical deconditioning, and a discharge date of [DATE] with primary discharge diagnosis acute encephalopathy. Discharge instructions documented, Discharge to: Skilled Nursing Facility, reason for visit: gen (general) weakness, and medication instructions included but not limited to methotrexate sodium 2.5 mg, 15 mg PO (by mouth) as directed once a week.A review of the EMR revealed the facility entered a physician's order for R1 dated [DATE] at (5:38 pm) as follows: Methotrexate sodium oral tablet 2.5 mg PO given six tablets PO once daily for RA (rheumatoid arthritis).A review of the care plan revealed R1 had a focus area for pain r/t the history of spinal stenosis and rheumatoid arthritis, initiated [DATE] and target date [DATE]. Interventions included, but were not limited to, Medication as ordered and document results, date initiated [DATE]. There was no other focus r/t rheumatoid arthritis, immunosuppressant medication, and/or methotrexate.During an interview on [DATE] at 3:25 pm, Licensed Practical Nurse (LPN) AA confirmed she made the transcription error and incorrectly entered the Methotrexate order for once daily instead of once a week. The interview further revealed that the Black Box Warning and Dose Alert got signed off because the charge nurse overrode the alert. R1 was readmitted from the hospital on [DATE], with orders including Methotrexate sodium 15 mg once weekly, and the nurse entered the frequency incorrectly. LPN AA incorrectly entered the order in the EMR on [DATE], and for once daily instead of once weekly. The pharmacy called back and said to change the order from 15 mg to 2.5 mg, take six tablets. They sent it out, it arrived on [DATE], and R1 started receiving the Methotrexate daily on [DATE]. The pharmacy completed a DRR (Drug Regimen Review) that they sent for, do not crush for a prostate (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

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	medication, but nothing was said about the once-daily dose of the methotrexate. LPN CC confirmed she entered the order 2.5 mg and entered it qd (every day) in the electronic system. She revealed there was no structured process in place at that time. There was auditing where the night shift reviewed the 24-hour report, but everyone had a different perception of what 24-hour checks meant. There was nothing in place at that time to catch med errors.During a telephone interview on [DATE] at 9:20 am, Pharmacist VV revealed she occasionally did DRR's for [Named] facility. She confirmed she received R1's hospital discharge orders for review, and they included medication orders. She also confirmed that she received medication orders from the facility for R1. She revealed she verified the orders from the facility and compared them to the hospital DC orders. She revealed that they had a two-person step, confirmed she checked R1's orders behind another pharmacist, but did not know the first pharmacist's name. She revealed she was in [Named city], and the first pharmacist to review orders was in (another) [Named] city. She revealed that no one else verified the orders because she was the second person, the final person in the process.During a telephone interview on [DATE] at 9:50 am, Physician ZZZ revealed she reviewed the admission orders for R1. She revealed that no one verified or compared the hospital orders, and the orders were entered into the system at the facility. The interview revealed she was aware of the med error on Friday evening, [DATE], about 7:00 pm. R1 had the flu, and she was notified earlier in the day that he was not getting better. Physician ZZZ revealed she thought it was just taking R1 longer to get over the flu, but she gave an order for labs, and they were collected that afternoon. Physician ZZZ revealed she was not expecting R1's WBC and platelets to be abnormal, but they were critically low. Physician ZZZ asked the nurse to review his meds. When R1 last received the methotrexate, and when the nurse revealed R1 was getting the methotrexate daily, she had R1 sent out to the hospital. Physician ZZZ revealed she saw him on [DATE], and he looked great at that time.During a telephone interview on [DATE] at 7:18 pm with Registered Nurse (RN) YYY (also the MDS Coordinator) confirmed that R1 was care planned with a focus on pain with an intervention, meds as ordered. RN YYY confirmed there was no other focus on the care plan for rheumatoid arthritis or methotrexate. RN YYY revealed that looking back, she should have been more specific and R1 should have had a specific focus for rheumatoid arthritis, administration of the Methotrexate or immunosuppressant medication, instead of lumping it under the focus for pain, but she grouped the pain and arthritis all together. She revealed she got resident updates by looking at orders, diagnoses, med list, and for new admissions, she looked at the hospital paperwork. She revealed she did not specifically remember seeing the Methotrexate order on the hospital discharge paperwork.A review of the facility's undated policy titled MDS - Care Plan revealed, Policy: 4. The care plan must address all identified needs and risks, including measurable goals and timetables, specify interventions, responsible staff and services, reflect the resident preferences, goals, and discharge planning. Required content includes medical diagnoses, treatments, functional status, ADLs (Activities of Daily Living), nutrition and dietary needs, psychosocial and mental status needs, equipment, services required, and plans for discharge or community return. 10. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities initially and when changes are made.Cross Reference F760The facility implemented the following actions to remove the IJ:1. On [DATE], a medication error was identified on R1. The physician ordered R1 to be sent to an acute care hospital for evaluation, and R1 was admitted to the hospital on [DATE] and expired on [DATE].2. On [DATE], staff education was initiated by a combination of the Director of Nursing (DON), the Assistant Directors of Nursing (ADONs), the Director of Education, and continued, to include 14/14 (100%) RNs (including the MDS Coordinator), 37/37 (100%) LPNs, 7/7 (100%) Certified Medication Technicians (CMAs), on the following: ensuring to follow the plan of care related to Medication Reconciliation process and Medication Administration Rights. The process included the admission Audit Tool, Charge Nurse Nightly Audit Tool, and High-Alert/Hazardous Medications.3. On [DATE], staff education was initiated by the DON and Director of Education, and continued, to include 13/14 (92.8%) charge nurses and the (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	MDS Coordinator related to the plan of care for New Admission/Readmission, Medication Reconciliation, the EMR Medication Alerts with the Physician and Nurse Practitioner (MD/NP) notification and documentation.4. On [DATE], a Quality Assurance Process Improvement (QAPI) meeting was conducted to discuss the medication error and the initial draft of the performance improvement plans. The team included the Administrator, DON, two ADONs, Director of Education, Chief Operating Officer (COO), and Medical Director (via phone).5. On [DATE], audits were initiated by the ADONs and continued: New/readmission Medication Reconciliation Documentation Audit. The audit included validating the 2-person check of admission/readmission orders and validating the DRR accuracy and timeliness. 84/84 (100%) residents were audited and 100% compliant.6. On [DATE], audits were initiated by the pharmacy: 1/1 resident on Methotrexate. Zero findings were noted.7. On [DATE], pharmacy-initiated implementation of internal process improvements, i.e., drug-specific pop-up alerts, visual aids on medication shelves, high-alert stickers, etc.8. All corrective actions were completed on [DATE]. The facility alleges that the immediate jeopardy was removed on [DATE].The State Survey Agency (SSA) validated the facility's IJ Removal Plan as Past Noncompliance, as follows:A review of the education records revealed education started on [DATE] for all licensed nurses and CMAs and included Medication Administration Rights.During multiple interviews, staff confirmed education with charge nurses started on [DATE] and included a revised nightly audit tool and nightly admission tool. Nursing staff were educated that if they see something in the record with no action, they must contact the doctor. Re-education is done if noncompliance or issues arise.A review of the education records revealed that education started on [DATE] for all charge nurses, was conducted by the DON, ADON, and/or Education Nurse, and included new admission/readmission medication reconciliation, EMR medication alerts with MD/NP notification and documentation.During multiple interviews with staff, confirmed education and included a revised nightly audit tool and nightly admission tool. Nursing staff were educated that if they see something in the record with no action, they must contact the doctor; alerts require a manual override and a 2-step process. This process was ongoing.During an interview on [DATE] at 5:30 pm, the DON confirmed that initial education, audits, and monitoring were initiated, and audits/monitoring were ongoing. A review of the QAPI meeting records confirmed that a QAPI meeting was held on [DATE], and the QAPI committee began discussions about the medication error and began developing a Process Improvement Plan (PIP) for the medication error. A review of the sign-in sheet confirmed that the Administrator, DON, 2 ADONs, Director of Education, COO, and Medical Director (via phone) were in attendance.During an interview on [DATE] at 5:30 pm, the DON confirmed that a QAPI meeting was held on [DATE].A review of completed audit tools confirmed that audits were initiated on [DATE] and checked for 2-person validation of all new admissions or readmissions and validated the DRR for accuracy and timeliness. Further review of the completed audit tools revealed 100% residents were audited and no concerns were identified.During an interview on [DATE] at 5:30 pm, the DON confirmed that audits were initiated and are ongoing. The nightly audit tool monitored for the DRR for accuracy, if it was completed correctly and timely, and checked for the 2-step person validating orders. No issues to date. If the ADON finds an issue, they will go immediately to the nurse and re-educate.During a telephone interview on [DATE] at 10:45 am with the Senior Pharmacist UU revealed what the pharmacy had put in place and included: Labeled all high-risk meds/shelves, added computer warning for high-risk meds, for manual override, they did high alert med training for all staff, evaluated what the pharmacist had going on/workload and evaluated their environment to decrease their distractions so they could concentrate more on verifying orders. Any verbal write-ups they enter as part of our Quality Assurance (QA). A write-up is completed with all errors. They did a Root Cause analysis to determine what happened and why it happened. The pharmacy revealed and confirmed follow-up action items that were implemented.During an interview with the Senior Manager Pharmacist UU, Administrator, and hall staff confirmed the pharmacy consultant came and did observations, education with staff, audits, and medication observations for all licensed nurses and CMAs.An interview on (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] at 5:30 pm, the DON confirmed that the pharmacy implemented processes, including drug-specific pop-up alerts, visual aids on medication shelves, and high-alert stickers, which were put in place for their facility. The pharmacist did education with staff, performed cart and storage room audits, and observed med administration with staff, did education, did medication observations, and checked the med storage rooms. The pharmacy consultant comes monthly and does education and DRR. The nurse consultant from the pharmacy comes every other month, and she does the med observations, checks the storage room, and carts.During a telephone interview on [DATE] at 10:45 am with the Senior Pharmacist, UU revealed that the pharmacy completed a Root Cause Analysis to determine what happened and why the error occurred. The pharmacy revealed and confirmed follow-up action items that were implemented. During the interview with the Senior Manager Pharmacist UU, Administrator, and multiple hall staff, confirmed that the pharmacy consultant came and did observations, education with staff, audits, and medication observations for all licensed nurses and CMAs.During an interview on [DATE] at 5:30 pm, the DON confirmed that the pharmacy implemented processes, including drug-specific pop-up alerts, visual aids on medication shelves, and high-alert stickers, which were put in place for their facility. The pharmacist did education with staff, performed cart and storage room audits, and observed med administration with staff, did education, did medication observations, and checked the med storage rooms. The pharmacy consultant comes monthly and does education and DRR. The nurse consultant from the pharmacy comes every other month, and she does the med observations, checks the storage room, and carts.It was determined and validated that all corrective actions were completed on [DATE], and the immediate jeopardy was removed on [DATE].

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and the facility policy titled Pharmacy Services and Medication Regimen Review (MRR), the facility failed to ensure that one of nine residents (R) (R1) was free from an unnecessary medication related to an excessive dose of Methotrexate Sodium tablets. Specifically, the facility administers Methotrexate 2.5 mg (milligram) once a day instead of once weekly, as ordered. As a result, R1 experienced medical complications requiring a transfer to an acute care hospital and expired on [DATE] due to Methotrexate toxicity.On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.The facility's Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy (IJ) on [DATE] at 4:27 pm. The noncompliance related to the IJ was identified as existing on [DATE].An Acceptable IJ Removal Plan was received on [DATE]. Based on observations, record reviews, interviews, and review of the facility's policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice were removed on [DATE] (Past Noncompliance).Findings included:A review of the electronic medical record (EMR) revealed that R1 was a readmission to the facility on [DATE] with diagnoses including, but not limited to, rheumatoid arthritis, dementia, spinal stenosis, syncope and collapse, and hypertension.A review of the hospital discharge notes for R1 dated [DATE] revealed that the hospital discharge medication list included Methotrexate sodium 2.5 milligram (mg) tablet 15 mg by mouth once a week.A review of the EMR revealed that upon R1's readmission on [DATE], a Licensed Practical Nurse (LPN) AA transcribed the medication order as Methotrexate sodium oral tablet 15 mg by mouth one time a day and sent a copy of the hospital discharge medication list to the pharmacy.A review of the Medication Administration Record (MAR) for R1 dated [DATE] through [DATE] revealed the Methotrexate sodium oral tablet 15 mg to give one tablet by mouth one time a day with a start date of [DATE] for RA (rheumatoid arthritis).A review of the MAR for R1 dated [DATE] revealed the Methotrexate sodium oral tablet 2.5 mg to give six tablets by mouth one time a day with a start date of [DATE] for RA.A review of the MAR for R1 dated [DATE] revealed the Methotrexate sodium oral tablet 2.5 mg to give six tablets by mouth one time a day with a start date of [DATE] for RA.A review of the MAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN CC administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN CC administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of the MAR (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the MAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of the (Named) pharmacy Admission/readmission or Change of Condition Drug Regimen Review (DRR) dated [DATE] revealed that Pharmacist VV completed the form and electronic signature with a date timestamp of [DATE] at 10:29 am. In the DRR Summary section, the hospital discharged orders and completed med rec form were checked to indicate that these documents were available to her. In the Nursing Recommendations - follow-up with the prescriber is NOT required: was noted, please update the administration time of tamsulosin to 6:00 pm, or approximately 30 min after supper. Please add 'do no crush' to finasteride and methotrexate orders. Update.There was no evidence that Pharmacist VV identified the discrepancy of Methotrexate frequency for once a week instead of daily.A review of the New RX electronically signed by Physician ZZZ dated [DATE] revealed Methotrexate Sodium oral tablet 15 mg, give one tablet by mouth one time a day for RA DO NOT CRUSH, and please update the order to 2.5 mg, take six tablets. There was no evidence that Physician ZZZ identified the discrepancy of Methotrexate frequency for once a week instead of daily.A review of the (Named) Pharmacy Current List of Residents Reviewed dated [DATE] and [DATE] revealed R1 was listed as having a medication regimen review. There was no evidence that indicated the discrepancy with the frequency of Methotrexate sodium tablets was identified.A review of the death certificate dated [DATE], which revealed R1's death was accidental secondary to Methotrexate toxicity.During an interview on [DATE] at 1:43 pm with Pharmacist TT (pharmacy consultant), who reported that she was not the pharmacist who did the original review of the medications for this resident upon admission to the facility, but she provides the monthly pharmacy review. There is no evidence that she identified the discrepancy with the Methotrexate frequency during her monthly review.During an interview on [DATE] at 9:50 am, Physician ZZZ revealed that she is familiar with R1 and had received the hospital discharge records. And what she recalled mostly was reviewing the discharge summary from the hospital and treatment orders. Physician ZZZ continued to state that after the resident was diagnosed with the flu, and was not getting better. We (staff) thought it was just taking him longer to get over it. She became aware of the medication error on [DATE]. R1 had lab work obtained, and he had critically low white blood cells and platelets. When she had asked the nurse when the last time R1 had the methotrexate drug, that is when she was told the medication had been given daily. She gave the order to send the resident out to the hospital.During an interview on [DATE] at 3:50 pm, Pharmacist YY revealed that she never saw the hospital discharge orders, and the conversion was made based on the order in the system. She was not aware of the medicator error until her immediate supervisor notified her.During an interview on [DATE] at 10:41 am, Pharmacist UU Senior Manager revealed that the Pharmacists involved received verbal and written counsel.During an interview on [DATE] at 8:05 pm, DON revealed the concern was noted through abnormal lab results, and the charge nurse notified the primary physician. After reviewing the orders, active and comparing them to discharge orders. The nurse was calling out the orders over the phone and comparing them to the hospital orders, and they (nurse and physician) realized the medication error. The methotrexate should have been given weekly instead of daily. The resident was sent to the hospital.During an interview on [DATE] at 6:56 pm, LPN SS revealed that she never saw the original order and was following the order in the electronic health system. And she was informed and educated after the medication error was discovered.Multiple attempts were made to interview (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LPN CC and LPN RR, but they were unavailable for an interview.A review of the policy titled Pharmacy Services with a last review date of [DATE] revealed that an admission Drug Regimen Review (DRR) is done for new admissions, readmissions, and patients with a change in condition related to medications or when otherwise requested by the center. The pharmacist should complete a DRR upon receipt of the request from the center (notification of the new admission/readmission/change in condition). This should be completed as close to the time of admission as possible. Any identified potential clinically significant medication issues in the DRR will be communicated to the physician with follow-up by midnight of the next calendar day. Contact the prescriber for additional orders and/or clarification, if needed. A follow-up with the prescriber should be completed by midnight of the following calendar day.A review of the facility's policy titled Medication Regimen Review (MRR) with a review date of [DATE] revealed that it is the intent of this policy to provide a review of the medication regimen of each patient at least monthly by the Consultant Pharmacist and report any irregularities. Guideline: The consultant pharmacist performs a comprehensive and systematic Medication Regimen review (MRR) for each patient monthly.Recommendations are provided to optimize medication safety, clinical appropriateness, and therapeutic efficiency. The pharmacist collaborates with the interdisciplinary care team and supports adherence to all applicable federal, state, and center-specific regulatory requirements.The facility implemented the following actions to remove the IJ:1. On [DATE], a medication error was identified on R1. The physician ordered R1 to be sent to an acute care hospital for evaluation, and R1 was admitted to the hospital on [DATE] and expired on [DATE].2. On [DATE], staff education was initiated by a combination of the Director of Nursing (DON), the Assistant Directors of Nursing (ADONs), the Director of Education, and continued, to include 14/14 (100%) RNs, 37/37 (100%) LPNs, 7/7 (100%) Certified Medication Technicians (CMAs), on the following: Medication Reconciliation process, Medication Administration Rights. The process included the admission Audit Tool, Charge Nurse Nightly Audit Tool, and High-Alert/Hazardous Medications.3. On [DATE], staff education was initiated by the DON and Director of Education, and continued, to include 13/14 (92.8%) charge nurses (1 on leave), on the following: New Admission/Readmission, Medication Reconciliation, the EMR Medication Alerts with the Physician and Nurse Practitioner (MD/NP) notification and documentation.4. On [DATE], a Quality Assurance Process Improvement (QAPI) meeting was conducted to discuss the medication error and the initial draft of the performance improvement plans. The team included the Administrator, DON, two ADONs, Director of Education, Chief Operating Officer (COO), and Medical Director (via phone).5. On [DATE], audits were initiated by the ADONs and continued: New/readmission Medication Reconciliation Documentation Audit. The audit included validating the 2-person check of admission/readmission orders and validating the DRR accuracy and timeliness. 84/84 (100%) residents were audited and 100% compliant.6. On [DATE], audits were initiated by the pharmacy: 1/1 resident on Methotrexate. Zero findings were noted.7. On [DATE], pharmacy-initiated implementation of internal process improvements, i.e., drug-specific pop-up alerts, visual aids on medication shelves, high-alert stickers, etc.8. All corrective actions were completed on [DATE]. The facility alleges that the immediate jeopardy was removed on [DATE].The State Survey Agency (SSA) validated the facility's IJ Removal Plan as Past Noncompliance, as follows:A review of the education records revealed education started on [DATE] for all licensed nurses and CMAs and included Medication Administration Rights.During multiple interviews, staff confirmed education with charge nurses started on [DATE] and included a revised nightly audit tool and nightly admission tool. Nursing staff were educated that if they see something in the record with no action, they must contact the doctor. Re-education is done if noncompliance or issues arise.A review of the education records revealed that education started on [DATE] for all charge nurses, was conducted by the DON, ADON, and/or Education Nurse, and included new admission/readmission medication reconciliation, EMR medication alerts with MD/NP notification and documentation.During multiple interviews with staff, confirmed education and included a revised nightly audit tool and nightly admission tool. Nursing (continued on next page)

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	115615	A. Building B. Wing	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	staff were educated that if they see something in the record with no action, they must contact the doctor; alerts require a manual override and a 2-step process. This process was ongoing.During an interview on [DATE] at 5:30 pm, the DON confirmed that initial education, audits, and monitoring were initiated, and audits/monitoring were ongoing. A review of the QAPI meeting records confirmed that a QAPI meeting was held on [DATE], and the QAPI committee began discussions about the medication error and began developing a Process Improvement Plan (PIP) for the medication error. A review of the sign-in sheet confirmed that the Administrator, DON, 2 ADONs, Director of Education, COO, and Medical Director (via phone) were in attendance.During an interview on [DATE] at 5:30 pm, the DON confirmed that a QAPI meeting was held on [DATE].A review of completed audit tools confirmed that audits were initiated on [DATE] and checked for 2-person validation of all new admissions or readmissions and validated the DRR for accuracy and timeliness. Further review of the completed audit tools revealed 100% residents were audited and no concerns were identified.During an interview on [DATE] at 5:30 pm, the DON confirmed that audits were initiated and are ongoing. The nightly audit tool monitored for the DRR for accuracy, if it was completed correctly and timely, and checked for the 2-step person validating orders. No issues to date. If the ADON finds an issue, they will go immediately to the nurse and re-educate.During a telephone interview on [DATE] at 10:45 am with the Senior Pharmacist UU revealed what the pharmacy had put in place and included: Labeled all high-risk meds/shelves, added computer warning for high-risk meds, for manual override, they did high alert med training for all staff, evaluated what the pharmacist had going on/workload and evaluated their environment to decrease their distractions so they could concentrate more on verifying orders. Any verbal write-ups they enter as part of our Quality Assurance (QA). A write-up is completed with all errors. They did a Root Cause analysis to determine what happened and why it happened. The pharmacy revealed and confirmed follow-up action items that were implemented.During an interview with the Senior Manager Pharmacist UU, Administrator, and hall staff confirmed the pharmacy consultant came and did observations, education with staff, audits, and medication observations for all licensed nurses and CMAs.An interview on [DATE] at 5:30 pm, the DON confirmed that the pharmacy implemented processes, including drug-specific pop-up alerts, visual aids on medication shelves, and high-alert stickers, which were put in place for their facility. The pharmacist did education with staff, performed cart and storage room audits, and observed med administration with staff, did education, did medication observations, and checked the med storage rooms. The pharmacy consultant comes monthly and does education and DRR. The nurse consultant from the pharmacy comes every other month, and she does the med observations, checks the storage room, and carts.During a telephone interview on [DATE] at 10:45 am with the Senior Pharmacist, UU revealed that the pharmacy completed a Root Cause Analysis to determine what happened and why the error occurred. The pharmacy revealed and confirmed follow-up action items that were implemented. During the interview with the Senior Manager Pharmacist UU, Administrator, and multiple hall staff, confirmed that the pharmacy consultant came and did observations, education with staff, audits, and medication observations for all licensed nurses and CMAs.During an interview on [DATE] at 5:30 pm, the DON confirmed that the pharmacy implemented processes, including drug-specific pop-up alerts, visual aids on medication shelves, and high-alert stickers, which were put in place for their facility. The pharmacist did education with staff, performed cart and storage room audits, and observed med administration with staff, did education, did medication observations, and checked the med storage rooms. The pharmacy consultant comes monthly and does education and DRR. The nurse consultant from the pharmacy comes every other month, and she does the med observations, checks the storage room, and carts.It was determined and validated that all corrective actions were completed on [DATE], and the immediate jeopardy was removed on [DATE].

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and the facility policy titled Pharmacy Services and Medication Regimen Review (MRR), the facility failed to ensure that one of nine residents (R) (R1) was free from a significant medication error related to facility staff administering Methotrexate 2.5 mg (milligram) once a day instead of once weekly, as ordered. As a result, R1 experienced medical complications requiring a transfer to an acute care hospital and expired on [DATE] due to Methotrexate toxicity.On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.The facility's Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy (IJ) on [DATE] at 4:27 pm. The noncompliance related to the IJ was identified as existing on [DATE].An Acceptable IJ Removal Plan was received on [DATE]. Based on observations, record reviews, interviews, and review of the facility's policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice were removed on [DATE] (Past Noncompliance).Findings included:A review of the Electronic Medical Record (EMR) revealed R1 was readmitted from the hospital to the facility on [DATE]. R1 had diagnoses that included but were not limited to metabolic encephalopathy, dementia, rheumatoid arthritis, hyperlipidemia, and anxiety.A review of [Named] hospital records revealed an admission date of [DATE] with chief complaint of physical deconditioning, and a discharge date of [DATE] with primary discharge diagnosis of acute encephalopathy. Review of hematology results on [DATE] revealed a white blood count (WBC) of 6.30 and a platelet count of 201. Discharge instructions included discharge to a skilled nursing facility, reason for visit: gen (general) weakness, follow-up with PCP (primary care physician) (Physician ZZZ was listed), and medication (med) instructions included but not limited to Methotrexate sodium 2.5 mg tablet 15 mg PO (by mouth) AS DIRECTED Once a week. {sic}A review of the physician's orders in the EMR revealed an order dated [DATE] at 3:22 pm for Methotrexate sodium oral tablet 15 mg by mouth one tablet one time a day. The order instructions read to give one tablet by mouth one time a day for RA (rheumatoid arthritis). There were a Black Box Warning alert and a Dose Warning alert. A review of the physician's orders in the EHR revealed an order dated [DATE] at 5:38 pm for Methotrexate sodium oral tablet 2.5 mg by mouth, six tablets one time a day. The order instructed to give six tablets by mouth one time a day for RA. The review also revealed there was a Black Box Warning alert and a Dose Warning alert. A review of the physician's orders in the EMR revealed an order for Methotrexate sodium oral tablet 15 mg by mouth one tablet one time a day for RA. DO NOT CRUSH. {sic} There was a Black Box Warning alert, and a Dose Warning alert.A review of the ?Black Box Warning detail' for Methotrexate sodium warned of serious adverse reactions, including death, have been reported with methotrexate.Closely monitor.A review of order detail revealed that Methotrexate was to be given one time a day, every day between 6:45 am-9:45 am for RA, start date [DATE], end date indefinite.A review of the [DATE] electronic Medication Administration Record (eMAR) revealed that the Methotrexate sodium 15 mg was scheduled to be administered once a day, in the morning, with a start date of [DATE]. The Methotrexate sodium 2.5 mg was to be given one time a day, with a start date of [DATE]. There was no specific time noted, only morning. Further review of the eMAR revealed R1 received 15 doses of Methotrexate in [DATE].A review of the [DATE] eMAR revealed that the Methotrexate sodium 2.5 mg six tablets by mouth one time a day for RA had a start date of [DATE], and a D/C (discontinue) date of [DATE]. There was no specific time noted; the medication was ordered for morning. Further review of the eMAR revealed that R1 received nine doses of methotrexate in [DATE].A review of the eMAR revealed that on [DATE], Licensed Practical Nurse (LPN) RR administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN CC administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN (continued on next page)

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	115615	A. Building B. Wing	04/27/2026

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	SS administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN CC administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN SS administered the medication to R1 as indicated by her initials.A review of the eMAR revealed that on [DATE], LPN RR administered the medication to R1 as indicated by her initials.A review of all physician orders, now discontinued, revealed R1 had five separate orders for Methotrexate sodium 15 mg, and two orders for Methotrexate sodium 2.5 mg. All orders are to be given every day for the diagnosis of RA.A review of the facility's investigation timeline documented that on Friday, [DATE], the ADON notified the DON that R1's WBC was critically low, and it had been identified that the wrong frequency of Methotrexate had been given. The Methotrexate was given daily instead of weekly as ordered.A review of the facility form titled Medication Discrepancy Report dated [DATE] for LPN AA revealed R1 received an unordered dose of medication, the dosage was greater than that which was ordered, the order was written correctly on the discharge orders, and the order was not transcribed onto the MAR properly. A written account by LPN AA described the incident and documented, Order was placed (incorrectly) on ([DATE]) and discontinued on ([DATE]).A review of a facility form titled Nursing Medication Discrepancy Report Follow-Up revealed a wrong dose/amount given and a transcription error. Report findings: Nurse transcribed Methotrexate 15 mg daily, and it should have been given weekly. (LPN AA) was the nurse making the error, and the report was signed by the DON and Administrator on [DATE].A review of the facility form titled Medication Discrepancy Report dated [DATE] for LPN CC revealed R1 received an unordered dose of medication, the dosage was greater than that which was ordered, the order was written correctly on the discharge orders, and the order was not transcribed/not entered in the EMR properly. A written account by LPN CC described the incident and documented, Order placed into (the EMR) for Methotrexate sodium 2.5 mg, give 15 mg (six tabs) daily, and the order was weekly. {sic}A review of a facility form titled Nursing Medication Discrepancy Report Follow-Up revealed wrong dose/amount given, the medication given resulted in adverse response., and a transcription error. Report findings: Nurse placed order in EMR for 15 mg of Methotrexate, and it should only be given once a week. (LPN CC) was the nurse making the error, and the report was signed by LPN CC, the DON, and Administrator on [DATE].A review of R1's EMR under (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115615	A. Building B. Wing	04/27/2026

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Progress Notes revealed an Order Note dated [DATE] at 1:35 pm, which revealed, This order is outside of the recommended dose or frequency. Methotrexate Sodium Oral Tablet 15 mg (Methotrexate sodium), give six tablets by mouth one time a day for RA. The dosing regimen of six tablets daily exceeds the usual dosing regimen of 0.25 to 1.6667 tablets every seven days. The frequency of daily exceeds the usual frequency of every seven days. The single dose of six tablets exceeds the maximum single dose of 1.6667 tablets. The usual dosing regimen is 0.25 to 1.6667 tablets every seven days. {sic}A review of R1's EMR revealed an Order Note dated [DATE] at 1:34 pm: This order is outside of the recommended dose or frequency. Methotrexate sodium oral tablet 15 mg, give one tablet by mouth one time a day for RA. The dosing regimen of one tablet daily exceeds the usual dosing regimen of 0.25 to 1.6667 tablets every seven days. The frequency of daily exceeds the usual frequency of every seven days. {sic}A review of R1's EMR revealed an Order Note dated [DATE] at 1:12 pm: This order is outside of the recommended dose or frequency. Methotrexate sodium oral tablet 15 mg, give one tablet by mouth one time a day for RA. The dosing regimen of one tablet daily exceeds the usual dosing regimen of 0.25 to 1.6667 tablets every seven days. The frequency of daily exceeds the usual frequency of every seven days. {sic}A review of R1's EMR revealed an order note entered by the DON dated [DATE] at 9:02 pm revealed, Transfer to Hospital Summary Note Text, [R1] went to the hospital on [DATE] and has not returned as of this time.A review of R1's EMR revealed an order note entered by the DON dated [DATE] at 9:02 pm revealed, EMS left with (R1) via stretcher.A review of R1's EMR revealed an order note entered by the DON dated [DATE] at 8:57 pm, which revealed, EMS arrived at facility. The resident was alert and talking. Resident was transferred to stretcher . without incident.A review of R1's EMR under Progress Notes revealed an order note entered by the DON dated [DATE] at 8:48 pm, which revealed, 911 called.A review of R1's EMR under Progress Notes revealed an order note entered by the DON dated [DATE] at 8:22 pm, which revealed that [Named] Physician ZZZ called requesting the resident to be sent to the ER (emergency room).A review of R1's EMR under Progress Notes revealed an order note entered by the DON dated [DATE] at 7:37 pm revealed, Health Status Note-Note Text: [Named Physician ZZZ] called approx 15 mins ago discussing Resident's lab work of WBC 1.23 and Plate 42,000 with dayshift charge nurse. Physician ZZZ stated that with the lab values, Leukemia may be a concern. Physician ZZZ obtained the [family member] phone number and was going to call and speak with her and would call us back. Physician ZZZ called back and reviewed the resident's medications. Physician ZZZ wants a CBC to be done about 7:00 am- 8:00 am and sent to the lab. Discontinue all medications except Flomax, and the resident can have Tylenol 650 mg by mouth as needed every six hours. {sic}A review of a Health Status Note dated [DATE] at 5:20 am documented, Bleeding noted to the mouth and tongue, resident unable to voice what happened, MD notified. Physician ZZZ with no new orders just continues to monitor.Late entry Health Status Note dated [DATE] at 5:38 pm documented, Resident stated it hurts when he eats or drinks. Noted sores in the mouth. Contacted Physician ZZZ, gave new order for Nystatin suspension, four times a day for 10 days. Contacted family member [Named], explained the risks and benefits. Verbalized understanding.A review of a Health Status Note dated [DATE] at 12:33 pm documented, Writer assessed resident. Noted continued productive cough. Resident stated he has body aches. Lung sounds are wet, bilateral lower lobes. Contacted Physician ZZZ. Gave new order to repeat CXR stat, albuterol neb every six hours as needed for two weeks, z pack 500 mg one-time dose, and 250 mg daily for four days. Contacted family member-[Named]. Notified of new orders. Explained the risks and benefits. Verbalized understanding. Resident is currently still taking [NAME] flu 75 mg twice a day for five days.Note [DATE] at 2:08 pm documented, RP inquiring about resident going to [Named] doctor for Arthritis infusions. Attempted to contact the office. Left voicemail for infusion nurse to contact the facility back. {sic}A review of a Health Status Note dated [DATE] at 2:26 pm documented, Resident upright in wheelchair. The resident is awake and alert with some confusion. Skin is warm and dry to the touch. Resident noted to have some coughing but is taking Tamiflu and Robitussin as needed for coughing. Resident tolerating (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115615	A. Building B. Wing	04/27/2026

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	meals well. Resident encouraged to increase fluid intake. The resident agreed to the plan of care.A review of an Order Note dated [DATE] 5:39 pm documented, This order is outside of the recommended dose or frequency. Methotrexate sodium oral tablet 2.5 mg, give six tablets by mouth one time a day for RA. The dosing regimen of six tablets daily exceeds the usual dosing regimen of 1 to 10 tablets every seven days. The frequency of daily exceeds the usual frequency of every seven days. Created [DATE] at 5:39 pm by LPN CC/Lead. (terminated [DATE], same day discovered).A review of an Order Note dated [DATE] at 2:21 pm documented, This order is outside of the recommended dose or frequency. Methotrexate sodium oral Tablet 15 mg, give one tablet by mouth one time a day for RA. DO NOT CRUSH. The dosing regimen of one tablet daily exceeds the usual dosing regimen of 0.25 to 1.6667 tablets every seven days. The frequency of daily exceeds the usual frequency of every seven days. Created [DATE] at 2:21 pm by LPN BB. {sic} (terminated)A review of nurse (LPN CC) termination paperwork dated [DATE] revealed the Associate's (LPN CC) employment was terminated on [DATE] because she did Unsatisfactory work related to medication administration. What she should have done was Administer medications according to the 5 Rights. The form was signed by the DON and Administrator. The Associate (LPN CC) did not sign the form.A review of critical lab results dated [DATE] included: WBC (white blood cell count): 1.23 with a reference range of 4.50-11.00, and PLT (platelets): 42 with a reference range of 150-350.A review of a Police report documented that on [DATE], they spoke with the Medical Examiner from Jacksonville, Florida, about a death. The Medical Examiner advised that they had been notified of the death of a w/m (white/male) named [R1] who was brought to the [Named local] hospital. The report states that R1 was originally at [Named] nursing home. He was prescribed Methotrexate and was supposed to be given the dosage once a week; however, the home-health nurse who was treating him was giving the dose daily for 29 days leading up to his transport to [Named local] Hospital for overdose. [Named local hospital] was unable to treat [Named R1], and he was transported to [Named hospital out of state]. He was transported to an inpatient hospice that same day with a diagnosis of acute respiratory failure with hypoxia, encephalopathy, and poisoning by antineoplastic and immunosuppressive drugs. During admission, the decedent's health continued to deteriorate, and on [DATE], he was pronounced. {sic}The Medical Examiner also advised that the decedent arrived at the [out of state] hospital on [DATE] around and was admitted for Methotrexate toxicity. It is also advised in the report that the Medical Examiner spoke with [Named R1's family member], who advised the Medical Examiner that R1's internal organs were burned from his tongue to his anus.A review of the Death Certificate revealed that R1's the cause of death ([DATE]) was Methotrexate toxicity.During an interview on [DATE] at 3:25 pm, LPN AA confirmed she made the transcription error and incorrectly entered the Methotrexate order for once daily instead of once a week. The interview further revealed that the Black Box Warning and Dose Alert got signed off because the charge nurse overrode the alert. R1 was readmitted from the hospital on [DATE], with orders including Methotrexate sodium 15 mg (milligrams) once weekly, and the nurse entered the frequency incorrectly. LPN AA incorrectly entered the order in the EMR on [DATE] and entered the order for once daily instead of once weekly. The pharmacy called back and said to change the order from 15 mg to 2.5 mg, take six tablets. They sent it out, it arrived on [DATE], and R1 started receiving the Methotrexate daily on [DATE]. The pharmacy completed a DRR (Drug Regimen Review) that they sent for, do not crush for a prostate medication, but nothing was said about the once-daily dose of the Methotrexate. LPN CC confirmed she entered the order 2.5 mg and entered it qd (every day) in the electronic system. She revealed there was no structured process in place at that time. There was auditing where the night shift reviewed the 24-hour report, but everyone had a different perception of what 24-hour checks meant. There was nothing in place at that time to catch med errors.During a telephone interview on [DATE] at 9:20 am, Pharmacist VV with [Named] Pharmacy revealed she occasionally did DRR's for [Named] facility. She confirmed she received the hospital DC orders for review on R1, and they included medication orders. She also confirmed that she received medication (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	orders from the facility for R1. She revealed she verified the orders from the facility and compared them to the hospital DC orders. She revealed that they had a two-person step, confirmed she checked R1's orders behind another pharmacist, but did not know the first pharmacist's name. She revealed she was in [Named city], and the first pharmacist to review orders was in (another) [Named] city. She revealed that no one else verified the orders because she was the second person, the final person in the process.During a telephone interview on [DATE] at 9:50 am, Physician ZZZ revealed she was familiar with R1, and she reviewed the Admissions orders from the hospital. What she recalled mainly from reviewing the DC summary from the hospital was treatment orders. She revealed that no one verified what was entered into the system at the facility. The interview revealed she was aware of the med error on Friday evening,[DATE], about 7:00 pm. R1 had the flu, and she was notified earlier in the day that he was not getting better. She stated, I thought it was just taking longer to get over the flu, but I gave an order for labs, and they were collected that afternoon. I was not expecting his WBC and platelets to be abnormal; they were critically low. I asked the nurse to review his meds and when he last received the Methotrexate. The nurse told me it was daily, and I had him sent out.During a telephone interview on [DATE] at 7:18 pm, RN (Registered Nurse) YYY (also the MDS Coordinator) confirmed R1 care planned for pain, with an intervention for meds as ordered. She felt the intervention for pain was followed because his pain was controlled. She confirmed there was no other focus on the care plan for rheumatoid arthritis or methotrexate, and looking back, R1 should have had a specific focus for rheumatoid arthritis or methotrexate/immunosuppressant medication instead of under the focus for pain. She revealed she should have been more specific but was grouping the pain and arthritis all together. She revealed she gets updates through looking at orders, diagnoses, the med list, and for new admissions, she looks at the hospital paperwork. She revealed she did not specifically remember seeing the order for the Methotrexate order on the hospital discharge paperwork.Cross Reference F656 The facility implemented the following actions to remove the IJ:1. On [DATE], a medication error was identified on R1. The physician ordered R1 to be sent to an acute care hospital for evaluation, and R1 was admitted to the hospital on [DATE] and expired on [DATE].2. On [DATE], staff education was initiated by a combination of the Director of Nursing (DON), the Assistant Directors of Nursing (ADONs), the Director of Education, and continued, to include 14/14 (100%) RNs, 37/37 (100%) LPNs, 7/7 (100%) Certified Medication Technicians (CMAs), on the following: Medication Reconciliation process, Medication Administration Rights. The process included the admission Audit Tool, Charge Nurse Nightly Audit Tool, and High-Alert/Hazardous Medications.3. On [DATE], staff education was initiated by the DON and Director of Education, and continued, to include 13/14 (92.8%) charge nurses (1 on leave), on the following: New Admission/Readmission, Medication Reconciliation, the EMR Medication Alerts with the Physician and Nurse Practitioner (MD/NP) notification and documentation.4. On [DATE], a Quality Assurance Process Improvement (QAPI) meeting was conducted to discuss the medication error and the initial draft of the performance improvement plans. The team included the Administrator, DON, two ADONs, Director of Education, Chief Operating Officer (COO), and Medical Director (via phone).5. On [DATE], audits were initiated by the ADONs and continued: New/readmission Medication Reconciliation Documentation Audit. The audit included validating the 2-person check of admission/readmission orders and validating the DRR accuracy and timeliness. 84/84 (100%) residents were audited and 100% compliant.6. On [DATE], audits were initiated by the pharmacy: 1/1 resident on Methotrexate. Zero findings were noted.7. On [DATE], pharmacy-initiated implementation of internal process improvements, i.e., drug-specific pop-up alerts, visual aids on medication shelves, high-alert stickers, etc.8. All corrective actions were completed on [DATE]. The facility alleges that the immediate jeopardy was removed on [DATE].The State Survey Agency (SSA) validated the facility's IJ Removal Plan as Past Noncompliance, as follows:A review of the education records revealed education started on [DATE] for all licensed nurses and CMAs and included Medication Administration Rights.During multiple interviews, staff confirmed education with charge nurses started on [DATE] and included a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115615	A. Building B. Wing	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baptist Village, Inc.	2650 Carswell Ave Waycross, GA 31502

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	revised nightly audit tool and nightly admission tool. Nursing staff were educated that if they see something in the record with no action, they must contact the doctor. Re-education is done if noncompliance or issues arise.A review of the education records revealed that education started on [DATE] for all charge nurses, was conducted by the DON, ADON, and/or Education Nurse, and included new admission/readmission medication reconciliation, EMR medication alerts with MD/NP notification and documentation.During multiple interviews with staff, confirmed education and included a revised nightly audit tool and nightly admission tool. Nursing staff were educated that if they see something in the record with no action, they must contact the doctor; alerts require a manual override and a 2-step process. This process was ongoing.During an interview on [DATE] at 5:30 pm, the DON confirmed that initial education, audits, and monitoring were initiated, and audits/monitoring were ongoing. A review of the QAPI meeting records confirmed that a QAPI meeting was held on [DATE], and the QAPI committee began discussions about the medication error and began developing a Process Improvement Plan (PIP) for the medication error. A review of the sign-in sheet confirmed that the Administrator, DON, 2 ADONs, Director of Education, COO, and Medical Director (via phone) were in attendance.During an interview on [DATE] at 5:30 pm, the DON confirmed that a QAPI meeting was held on [DATE].A review of completed audit tools confirmed that audits were initiated on [DATE] and checked for 2-person validation of all new admissions or readmissions and validated the DRR for accuracy and timeliness. Further review of the completed audit tools revealed 100% residents were audited and no concerns were identified.During an interview on [DATE] at 5:30 pm, the DON confirmed that audits were initiated and are ongoing. The nightly audit tool monitored for the DRR for accuracy, if it was completed correctly and timely, and checked for the 2-step person validating orders. No issues to date. If the ADON finds an issue, they will go immediately to the nurse and re-educate.During a telephone interview on [DATE] at 10:45 am with the Senior Pharmacist UU revealed what the pharmacy had put in place and included: Labeled all high-risk meds/shelves, added computer warning for high-risk meds, for manual override, they did high alert med training for all staff, evaluated what the pharmacist had going on/workload and evaluated their environment to decrease their distractions so they could concentrate more on verifying orders. Any verbal write-ups they enter as part of our Quality Assurance (QA). A write-up is completed with all errors. They did a Root Cause analysis to determine what happened and why it happened. The pharmacy revealed and confirmed follow-up action items that were implemented.During an interview with the Senior Manager Pharmacist UU, Administrator, and hall staff confirmed the pharmacy consultant came and did observations, education with staff, audits, and medication observations for all licensed nurses and CMAs.An interview on [DATE] at 5:30 pm, the DON confirmed that the pharmacy implemented processes, including drug-specific pop-up alerts, visual aids on medication shelves, and high-alert stickers, which were put in place for their facility. The pharmacist did education with staff, performed cart and storage room audits, and observed med administration with staff, did education, did medication observations, and checked the med storage rooms. The pharmacy consultant comes monthly and does education and DRR. The nurse consultant from the pharmacy comes every other month, and she does the med observations, checks the storage room, and carts.During a telephone interview on [DATE] at 10:45 am with the Senior Pharmacist, UU revealed that the pharmacy completed a Root Cause Analysis to determine what happened and why the error occurred. The pharmacy revealed and confirmed follow-up action items that were implemented. During the interview with the Senior Manager Pharmacist UU, Administrator, and multiple hall staff, confirmed that the pharmacy consultant came and did observations, education with staff, audits, and medication observations for all licensed nurses and CMAs.During an interview on [DATE] at 5:30 pm, the DON confirmed that the pharmacy implemented processes, including drug-specific pop-up alerts, visual aids on medication shelves, and high-alert stickers, which were put in place for their facility. The pharmacist did education with staff, performed cart and storage room audits, and observed med administration with staff, did education, did medication observations, and checked the med storage (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	rooms. The pharmacy consultant comes monthly and does education and DRR. The nurse consultant from the pharmacy comes every other month, and she does the med observations, checks the storage room, and carts.It was determined and validated that all corrective actions were completed on [DATE], and the immediate jeopardy was removed on [DATE].