STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425078	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Commons Health and Rehabilitation Center	1110 Marshall Road Greenwood, SC 29646

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, facility policy review, and manufacturer guideline review, the facility failed to ensure the medication administration error rate was less than 5 percent (%). The facility had 2 medication errors out of 31 opportunities, affecting 2 residents (Residents (R)48 and R65) of 8 residents reviewed during the medication administration task, resulting in a medication error rate of 6.45%. Findings include: 1. Review of the facility policy titled, Insulin Injection Administration Procedures, revised on 10/10/2024, indicated, the purpose was, To aid oxidation and utilization of the blood sugar by the tissues and to control the blood sugar levels in residents with diabetes mellitus through the correct administration of insulin. The policy also indicated, If using insulin pen expel 2 units of insulin to prime the needle then dial up correct dose of insulin to be given. Review of an Instructions for use Humalog ([NAME]-ma-log) KwikPen [a disposable insulin pen used to control blood sugar levels in people with diabetes] (insulin lispro) injection, for subcutaneous use 3 mL [milliliter] single-patient-use pen (100 units per mL), instruction manual, revised in 07/2023, indicated, Prime before each injection. The document also indicated, Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your Pen, turn the Dose Knob to select 2 units. Step 7: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and 0 is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. The manufacturer instructions continued, Step 9: Turn the Dose Knob to select the number of units you need to inject. The manufacturer instructions continued, Step 10: Choose your injection site. then, Step 11: Insert the Needle into your skin. Review of a Clinical/Charting Snapshot, dated 02/11/2026, indicated the facility admitted R48 on 08/04/2025. According to the Clinical/Charting Snapshot, the resident had a medical history that included but was not limited to diagnoses of type 1 diabetes mellitus (an autoimmune disease where the body does not produce enough insulin to maintain blood glucose levels) with unspecified complications and Alzheimer's (a brain condition that causes memory loss and cognitive impairment) disease. Review of R48's Physician Orders for the timeframe 02/01/2026 through 02/28/2026, contained an order, with a start date of 08/04/2025 for Humalog KwikPen 100 units/1 milliliter solution (insulin lispro) subcutaneous, per sliding scale. The Physician Orders also contained an order for Humalog KwikPen 100 units/1 milliliter solution (insulin lispro) 2 units subcutaneous with breakfast, lunch, and dinner at 8:00 AM, 12:00 PM, 5:00 PM. During an observation of medication administration on 02/11/2026 at 12:12 PM, Licensed Practical Nurse (LPN)1 stated R48's blood glucose level was 184 milligrams per deciliter (mg/dL) and that the resident would receive 2 units of Humalog KwikPen insulin per sliding scale coverage and another 2 units of Humalog KwikPen insulin per routine order. LPN1 applied a new needle onto the Humalog KwikPen and primed the pen with 2 units of insulin. LPN1 then removed the needle and applied a new needle to the Humalog KwikPen. LPN1 did not reprime the Humalog KwikPen after applying the new needle. LPN1 then dialed the Humalog KwikPen to 4 units of insulin and (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered the medication. During an interview on 02/11/2026 at 5:50 PM, LPN1 stated she should have primed R48's Humalog KwikPen insulin with 2 units after changing the needle. LPN1 stated the purpose of priming the insulin pen was to get air bubbles out of the pen and to ensure the resident received the ordered dose of insulin. 2. Review of the facility policy titled, Oral Inhalers, revised on 05/03/2021, indicated, Resident may need to rinse mouth with water after certain inhalers. Review of a How to Use Wixela Inhub (generic equivalent for Advair Diskus) (a medication used to prevent asthma attacks), instruction manual, dated 2021, indicated, Rinse your mouth with water after breathing in the medicine. Spit out the water. Do not swallow it. Review of a Clinical/Charting Snapshot, dated 02/12/2026, indicated the facility admitted R65 on 05/07/2024. According to the Clinical/Charting Snapshot, the resident had a medical history that included but was not limited to a diagnosis of unspecified asthma, uncomplicated. The Clinical/Charting Snapshot also included an active physician order, dated 11/24/2025 for Advair Diskus 250/50 disk (fluticasone propionate/salmeterol xinafoate) one puff inhalation twice a day. During an observation of medication administration on 02/12/2026 at 9:02 AM, Registered Nurse (RN)3 administered R65's Wixela Inhub (Advair diskus). RN3 did not instruct the resident to rinse their mouth and spit out the water after breathing in the medication. During an interview on 02/12/2026 at 2:20 PM, RN3 stated there was no need for R65 to rinse their mouth after breathing in the inhaler because there was no doctor's order to do so. RN3 stated she did not know there was a need to rinse the resident's mouth following the inhaler administration. During an interview on 02/12/2026 at 3:24 PM, RN3 stated she should have instructed the resident to rinse their mouth after administering Wixela Inhub (Advair diskus) to prevent thrush or mouth irritation. During an interview on 02/13/2026 at 10:55 AM, the Director of Nursing (DON) stated the facility staff should follow their policy and the manufacturer's recommendations when administering medications. During an interview on 02/13/2026 at 2:00 PM, the [NAME] President of Operations/Administratorˆ(VPO/ADM) stated the facility staff should have followed the manufacturer's instructions when administering the medications. The VPO/ADM stated the facility staff should have primed the insulin pen for R48 and should have instructed R65 to rinse their mouth.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, facility document and policy review, the facility failed to ensure medications were stored safely and securely for 1 (Medication Cart #2) of 4 medication carts. Findings include: Review of the facility policy titled, Storage of Medications, revised on 06/07/2024, indicated, To ensure that medications are stored safely, securely and properly. Medication supply is accessible only to licensed nursing personnel and pharmacy personnel. The policy further indicated, 2. Medication rooms, carts and medication supplies should be locked or attended by persons with authorized access. During an observation and concurrent interview on 02/11/2026 at 5:26 PM, an unattended sealed blue bag was observed on top of Medication Cart #2. Medication Cart #2 was in the hallway outside of a resident room. Registered Nurse (RN)2 stated that the bag contained nine non-narcotic medications that were delivered to the facility. RN2 stated she usually left the newly delivered medications inside the nurses' station. RN2 stated she should not have left the bag containing the medications on top of the medication cart unattended, as anyone, including residents, could have taken them. RN2 stated residents might have taken medications that were not intended for them, which could result in a medication allergy or adverse drug effect. Review of a facility document titled, Prescriptions Delivered to [name of facility, address of facility] dated 02/11/2026 at 10:37 AM, indicated the following medications were delivered: milk of magnesia oral suspension (a medication used to treat constipation), Aquaphor ointment (a medication used to keep wounds moist), cyclobenzaprine hydrochloride tablets (a medication used to treat muscle spasms), metoprolol tablets (a medication used to treat high blood pressure and heart failure), irbesartan tablets (a medication used to treat hypertension), levothyroxine sodium (a medication used to treat low thyroid hormone) tablets, lactulose solution (a medication used to treat constipation or to maintain ammonia levels), pantoprazole sodium tablets (a medication used to treat excessive stomach acid), and ondansetron tablets (a medication used to treat nausea and vomiting). The document further indicated, I certify the above items/services provided by [name of pharmacy] have been authorized by the prescriber and received by me on behalf of the listed patients. The form was not signed by anyone to indicate the medications had been delivered and received. During an interview on 02/13/2026 at 10:55 AM, the Director of Nursing (DON) stated the facility staff should follow their policy in ensuring medications they received from the pharmacy were locked. The DON stated anyone could have access to medications if left on top of the medication cart. During an interview on 02/13/2026 at 2:00 PM, the [NAME] President of Operations/Administrator (VPO/ADM) stated the facility staff should not leave medications on top of the medication cart, as any resident could take them. The ADM stated staff should store medications in the medication cart or medication storage room.