STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265792	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens of O'Fallon	7068 South Outer 364 O Fallon, MO 63368

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 interview and record review, the facility failed to ensure one resident (Resident #17), in a review of 17 sampled residents, was free from a significant medication error, when staff administered antibiotic ear drops into the resident's right eye. The facility census was 165.Review of the facility policy, Medication Administration, revised January 2021, showed the following:)-Read labels on all medications three times: -a. Before removing medication from cart; -b. Before pouring; -c. After pouring;-Cross-check all medication orders that are new, or that you question; -a. Check physician's order against the electronic Medication Administration Record (eMAR); -b. Check eMAR against label on drug container; -c. Check label on drug container against the physician's order. Review of the Certified Medication Technician Student Manual, 2008 revision, showed to avoid medication errors, remember the five Rights of Medication Administration which included the following:-Right resident; -Right medication; -Right dose; -Right route;-Right time. 1. Review of Resident #17's undated face sheet showed the following:-He/She admitted on [DATE];-He/She was his/her own responsible party;-Diagnoses included otitis media (an infection of the middle ear). Review of the resident's hospital discharge orders, dated 01/08/26, showed an order for ciprofloxacin hydrochloride (a broad-spectrum antibiotic used to treat various bacterial infections) 0.3% solution; two drops into the right ear four times daily. Review of Drugs.com for ciprofloxacin ear drops showed the following:-Ear drops and eye drops are not interchangeable, even though they contain the same antibiotic. Eye drops can sometimes be used in the ear, but ear drops should never be used in the eyes. Ear drops are often more acidic, causing significant pain and irritation if placed in the sensitive eyes;-Putting Cipro ear drops in the eye will likely cause immediate, intense burning, itching, redness, blurred vision, and swelling;-Ear drops are not formulated to be pH-balanced for eye tissue;-Always check the label to ensure it says ophthalmic for eye use or otic for ear use. Review of the resident's Physician Order Sheet (POS), dated 01/08/26 through 01/17/26, showed an order for ciprofloxacin hydrochloride 0.2%, instill two drops into the right ear four times daily at 8:00 A.M., 12:00 P.M., 4:00 P.M., 8:00 P.M. (Review showed no physician's orders for eye drops.) Review of the resident's Medication Administration Record (MAR) for 01/17/26 showed Registered Nurse (RN) A administered two drops of ciprofloxacin hydrochloride 0.2% in the ear at 4:00 P.M. Review of the resident's progress notes, dated 01/18/26 at 11:59 A.M., showed the following:-The resident received ciprofloxacin ear drop to his/her right eye last night (01/17/26); -No redness or discharge noted; -The resident reported some blurred vision. During an interview on 02/18/26 at 2:55 P.M., the resident said the following:-After RN A administered the ear medication into his/her right eye and left the room, he/she had immediate pain and blurred vision. He/She called another nurse into the room right away to let him/her know about his/her pain and blurred vision and asked if they knew why RN A had administered eye drops;-RN A explained to him/her that he/she had made a medication error by placing his/her ear drops into his/her right eye. During interviews on 02/05/26 at 1:00 P.M., 2:05 P.M., and 3:00 (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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(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	P.M., Registered Nurse (RN) A said the following:-He/She was the nurse who made the medication error; -He/She read the label on the ear drops as eye instead of ear; -He/She administered the medication (Cipro) into the resident's right eye rather than to the resident's right ear;-The certified medication technicians (CMTs) normally administered the eye drops and ear drops; -He/She worked as a CMT on 01/17/26. During interview on 2/17/26 at 2:25 P.M., RN D said the following:-He/She worked evening shift (2:45 P.M. - 11:15 P.M.) on 01/17/26;-He/She checked on the resident on 01/17/26 after the medication error; -The resident complained of blurred vision;-The resident rubbed his/her eyes but did not mention pain;-He/She did not notice any redness or irritation to the resident's eye throughout the night. During an interview on 02/05/26 at 2:10 P.M., the Nurse Educator said the following:-RN A called him/her to report he/she placed ear drops into the resident's right eye; -RN A told him/her that he/she notified the physician and got an order to flush the eye;-He/She in-serviced RN A over the phone regarding the five rights of medication administration;-He/She had a CMT meeting on 01/29/26 and went over the eye medication administration competency form. He/She was still trying to catch all CMT and nursing staff for inservicing related to medication administration. During interviews on 02/05/26 at 2:55 P.M., Licensed Practical Nurse (LPN) F said he/she could not recall the last time he/she was in-serviced on the rights of medication administration. During an interview on 02/05/26 at 2:45 P.M., Licensed Practical Nurse (LPN) E said he/she had not received any in-service training on eye drop or ear drop medication administration. During an interview on 02/05/26 at 3:20 P.M., the Administrator said the following:-She expected staff to follow the rights of medication administration and facility policies;-CMTs typically administered eye drops, but all nursing staff could be asked to administer medications;-She did not think all staff needed to receive in-servicing regarding medication administration because RN A said he/she made the mistake. #2720686