

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2026
NAME OF PROVIDER OR SUPPLIER Rancho Mirage Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 39950 Vista Del Sol Rancho Mirage, CA 92270	
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to meet professional standards when two of two toured medication rooms had expired COVID-19 (coronavirus disease 2019, contagious infection responsible for the death of over one million people in the United States) test kits. This failure had the potential for inaccurate test results which could cause missed COVID-19 infections and possible infection spread in the facility. Findings: 1. During a concurrent observation and interview on [DATE], at 2:29 p.m. with Licensed Vocational Nurse 2 (LVN 2), the Medication room [ROOM NUMBER] tour was conducted. There was one opened box of COVID-19 test kits in the room. LVN 2 stated the test kit expired on [DATE], and she would remove it from the room. 2. During a concurrent observation and interview on [DATE], at 2:46 p.m. with LVN 3, the Medication room [ROOM NUMBER] tour was conducted. There were six boxes of COVID-19 test kits in the room with an expiration date of [DATE]. There was also an opened box containing one combination flu and COVID-19 test kit with an expiration date of February 24, 2026. LVN 3 stated she would give the expired test kits to the Infection Preventionist (IP). During an interview on [DATE], at 2:25 p.m., the IP stated the test kits found in Medication rooms [ROOM NUMBERS] were expired. During a telephone interview on [DATE], at 10:50 a.m., the Consultant Pharmacist (CP) stated the expectation was expired COVID-19 test kits were discarded in the medication waste bin. The CP stated, anything expired shouldn't be on the shelf. During an interview on [DATE], at 12:07 p.m., the IP stated the facility did not have a policy addressing expired supplies. The IP stated the standard of practice was for expired COVID-19 test kits to be thrown away. The IP stated expired test kits were supposed to be discarded one week prior to the expiration date and confirmed this was not done. The IP stated there was a concern of inaccurate test results if the expired test kits were used. During an interview on [DATE], at 10:28 a.m., the Director of Nursing (DON) stated the expired COVID-19 test kits should not have been in the medication rooms. The DON stated if the expired test kits were accidentally used, there was a concern of false readings.		

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper labeling and storage of medications according to the facility policy and procedures (P&P) and manufacturer's specifications when: 1. Inhaled medications were not labeled with an open date in two of four reviewed medication carts (Medication Carts 1 and 2), and 2. One inhaled medication was not stored inside the foil pouch as required by the manufacturer in one of four reviewed medication carts (Medication Cart 2). These deficient practices had the potential to expose residents to deteriorated or ineffective medications, which could lead to the use of unsafe and ineffective medications for the residents. Findings: 1a. During a concurrent observation and interview on [DATE], at 10:49 a.m. with Licensed Vocational Nurse 5 (LVN 5), Medication Cart 1 was reviewed. The medication cart contained one opened box of generic DuoNeb (ipratropium bromide 0.5 milligrams [mg] and albuterol sulfate 3 mg inhalation solution for nebulizer, a machine that turns liquid inhaled medications into mist, to treat chronic obstructive pulmonary disease [COPD-a chronic lung disease causing difficulty in breathing]) for Resident 20 with an opened foil pouch of the medication inside. The pharmacy label on the box indicated, Fill Date: [DATE]. The box was also labeled, OD [open date]: [DATE], in black marker. LVN 5 stated the DuoNeb box was supposed to be labeled with the date opened. LVN 5 stated she did not know why the open date was before the medication was filled by the pharmacy. LVN 5 stated the medication needed to be discarded because there were too many dates on the box and she did not know when it was opened. LVN 5 stated all inhaled medications needed to be labeled with the open date because some medications expired after being opened. 1b. During a concurrent observation and interview on [DATE], at 11:04 a.m. with LVN 5, Medication Cart 2 was reviewed. The medication cart contained one opened box of generic DuoNeb 0.5-3 mg inhalation solution for Resident 101 with an opened foil pouch of the medication inside. LVN 5 acknowledged the box did not have a labeled open date. During an interview on [DATE], at 11:38 a.m., the Director of Staff Development (DSD) stated the nurses were supposed to label DuoNeb boxes with the open date. The DSD stated he did not know when Resident 20's DuoNeb was opened because the labeled open date was before the pharmacy fill date. 2. During a continued concurrent observation and interview on [DATE], at 11:04 a.m. with LVN 5, Medication Cart 2 was reviewed. The medication cart also contained a clear plastic bag with six doses of generic DuoNeb 0.5-3 mg inhalation solution. The bag was labeled for Resident 101 with a fill date of [DATE]. The bag had a yellow sticker which indicated, Once the product is removed from the pouch, discard unused medication. LVN 5 stated she did not know the meaning of the yellow sticker. During a telephone interview on [DATE], at 10:50 a.m., the Consultant Pharmacist (CP) stated DuoNeb was supposed to be stored in the foil pouch to protect from light. During a telephone interview on [DATE], at 11:18 a.m., the Consultant Pharmacist (CP) stated DuoNeb vials were supposed to be kept in the foil pouch after opening. The CP stated the medication needed to be used within 14 days after removing from the foil pouch because of light exposure. During an interview on [DATE], at 11:38 a.m., the DSD stated Resident 101's DuoNeb was supposed to be stored in the foil pouch, not a clear plastic bag. The DSD stated the facility would not know if the medication was expired without proper labeling and storage. The DSD stated if the open date or expiration date was unknown, the medication needed to be replaced. During an interview on [DATE], at 1:03 p.m., the Director of Nursing (DON) stated the expectation was for opened inhalers and nebulizer medications to be labeled with the open date. The DON stated DuoNeb was not supposed to be stored in a clear plastic bag. The DON stated if medications were not labeled or stored properly, the nursing staff were supposed to remove them from the medication carts so they were not used for residents. A review of the Prescribing Information (PI, detailed description of a medication that is available to clinicians) for ipratropium and (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	albuterol nebulizer solution (generic for DuoNeb), dated [DATE], retrieved from DailyMed, indicated: .PROTECT FROM LIGHT. The unit-dose vial should remain stored in the protective foil pouch until time of use. and .Once removed from the foil pouch, the individual vials should be used within one week. A review of the facility's policies and procedures (P&P), titled, Medication Labeling and Storage, undated and provided by the DON, indicated, If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure food was served at a palatable temperature consistent with resident preferences for five of 91 sampled residents (Residents 19, 27, 68, 75, and 79) This failure had the potential to diminish resident satisfaction with meals and adversely affect residents' enjoyment of dining and food intake. Findings: On May 18, 2026, at 11:12 a.m., an interview was conducted with Resident 27. Resident 27 stated, hot foods were sometimes cold and cold foods were not cold as should be. On May 19, 2026, at 9:11 a.m., an interview was conducted with Resident 19. Resident 19 stated that hot food was cold during every meal. On May 19, 2026, at 11:10 a.m., an interview was conducted with Resident 68. Resident 68 stated that hot foods were cold. On May 20, 2026, at 12:47 p.m., an interview was conducted with Resident 79 and Resident 75. Resident 79 stated food temperatures were not as hot as expected. Resident 75 stated that food was cold and never served hot. On May 20, 2026, from 11:23 to 12:23 p.m., observations were conducted in the kitchen during meal service. Multiple meal items were removed from the steam table, plated three to four trays at a time, and held on a shelf above the steam table for approximately one to three minutes before being covered and placed into meal carts for service. On May 20, 2026, at 12:32 p.m., an observation and interview were conducted with Dietary Manager (DM 1), two sample meal trays were tested for temperature. Pureed meat sauce with noodles measured 115 degrees Fahrenheit (F), and pureed green beans measured 105 F. DM 1 stated the temperatures did not meet the department's expected serving temperature of 120 F. DM 1 further stated temperatures below the department's expected standard could affect meal palatability and resident satisfaction. DM 1 stated residents should receive hot and cold foods at appropriate serving temperatures. On May 21, 2026, at 8:53 a.m., an interview was conducted with the Registered Dietitian (RD). The RD stated staff were expected to serve food directly from the steam table onto plates and cover them immediately, avoiding hold times greater than two minutes as a standard practice. The RD stated hot food should be maintained at temperatures that remain appealing to residents. The RD further stated meal quality and enjoyment depend on proper temperature control and timely delivery from the kitchen to the resident. The RD stated meals that did not meet resident expectations should be replaced with freshly prepared food. On May 21, 2026, at 12:30 p.m., follow up interview were conducted with Residents 19 and 68. Resident 19 stated the meal was not cold but needed to be warmer. Resident 68 stated the rice and vegetables were not hot enough. A review of the policy and procedure titled, Food Preparation and Service, dated November 2022, indicated, .food distribution.proper hot and cold temperatures are maintained during food distribution and service.A review of the culinary service group, a nationally recognized food service management company, article titled, Food safety 101 dated January 2021, indicated, .Food must be prepared by methods that conserve nutritive value, flavor, and appearance .Food and drink must be palatable, attractive, and at a safe and appetizing temperature.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented for three of seven residents (Residents 4, 7, and 78) during the medication administration observation, when: 1. Nursing staff failed to follow enhanced barrier precautions (EBP, infection control practice) for one resident (Resident 4), 2. Nursing staff failed to properly clean and disinfect the prefilled insulin (medication for diabetes to treat high blood sugar) pen before use for one resident (Resident 7), and 3. Nursing staff failed to properly clean and disinfect a shared glucometer (blood glucose [sugar] meter to measure the amount of sugar in the blood) for two residents (Residents 78 and 7). These failures had the potential to expose residents to infection and to compromise residents' health and safety in the facility. Findings: 1. During a medication pass observation on May 18, 2026, at 10:13 a.m., Licensed Vocational Nurse 6 (LVN 6) was observed preparing five medications for Resident 4. An orange flyer posted at Resident 4's doorway indicated STOP - ENHANCED BARRIER PRECAUTIONS. LVN 6 entered Resident 4's room and put on gloves before administering the medications through Resident 4's gastrostomy tube (G-tube, small tube placed through the abdominal wall into the stomach, used to provide feeding formula and/or administer medications). LVN 6 did not wear a gown while administering medications to Resident 4. A review of Resident 4's physician's orders, dated January 29, 2025, indicated Resident 4 had orders for Enhanced Barrier Precautions due to G-tube. During an interview on May 18, 2026, at 2:29 p.m., LVN 2 stated nurses were supposed to wear a gown and gloves when handling a G-tube. During an interview on May 20, 2026, at 12:13 p.m., the Infection Preventionist (IP) stated nurses were supposed to wear a gown when giving medications through a G-tube. The IP stated he was aware LVN 6 did not wear a gown during Resident 4's morning medication pass on May 18, 2026. The IP stated Resident 4 had enhanced barrier precautions (EBP) in place. The IP stated, for residents with EBP, the gown acted as a barrier between the nurse and the resident to prevent the resident from getting an infection. The IP further stated for a resident with a serious infection, the nurse's gown also prevented the infection from spreading to other residents. During an interview on May 21, 2026, at 10:28 a.m., the Director of Nursing (DON) stated the nurse was supposed to wear a gown during Resident 4's morning medication pass to follow EBP. The DON stated the gown was a barrier to prevent infection transmission. A review of the facility's policies and procedures (P&P), titled, Enhanced Barrier Precautions, dated April 2024, indicated: .Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multidrug resistant organisms (MDROs [infections that do not respond to antibiotics]) to residents. and .Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include device care or use (.feeding tube.) 2. During a medication pass observation on May 18, 2026, at 4:29 p.m. in the hallway outside of Resident 7's room, LVN 4 was observed preparing one medication, Novolin R FlexPen (brand name of prefilled insulin pen), for Resident 7. LVN 4 removed the insulin cap and attached the needle to the pen tip. LVN 4 did not wipe the pen tip with anything before attaching the needle. LVN 4 then administered the medication to Resident 7. During an interview on May 18, 2026, at 4:39 p.m., LVN 4 stated he was supposed to wipe the insulin pen tip with an alcohol swab before attaching the needle and he forgot to do it for Resident 7. During an interview on May 19, 2026, at 2:18 p.m., the IP stated nurses were supposed to clean the insulin pen tip with an alcohol swab before attaching the needle. The IP stated the pen tip needed to be cleaned with an alcohol swab to prevent bloodborne pathogens (infections carried in and spread through blood). During an interview on May 21, 2026, at 10:28 a.m., the DON stated insulin pen tips were supposed to be wiped before attaching the needle. A review of the Prescribing Information (PI, detailed description of a medication that is available to clinicians) for Novolin R FlexPen, dated November 23, 2022, retrieved from DailyMed, indicated, .Pull off the pen cap. Wipe the rubber stopper with an alcohol swab. A review of the facility's P&P, titled, Prefilled Insulin Pen Device Prep & Administration, dated February 2026, indicated, Clean the rubber seal on the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	insulin cartridge with a sterile alcohol swab. 3. During a concurrent observation and interview on May 18, 2026, at 3:21 p.m. outside Resident 78's room, LVN 4 was observed exiting the room with a glucometer. LVN 4 stated he checked Resident 78's blood sugar. LVN 4 wiped the glucometer with an alcohol swab and put the glucometer away in the medication cart. During an observation on May 18, 2026, at 4:29 p.m. in Resident 7's room, LVN 4 was observed using the glucometer to check Resident 7's blood sugar. LVN 4 returned the glucometer to the medication cart without wiping it. During a concurrent observation and interview on May 18, 2026, at 4:39 p.m. outside Resident 7's room, LVN 4 stated nurses were supposed to wipe the shared glucometer with an alcohol swab before and after checking blood sugar for each resident for cleanliness. LVN 4 then used an alcohol swab to wipe the glucometer. During an interview on May 19, 2026, at 9:49 a.m., LVN 2 stated nurses were supposed to use the disinfecting wipes with the purple lid (brand name Sani-Cloth) to sanitize the glucometer between residents. During an interview on May 19, 2026, at 2:08 p.m., the IP stated nurses were supposed to use bleach wipes or the disinfecting wipes with the purple lid to sanitize the glucometer between residents. The IP stated alcohol swabs were not acceptable because the alcohol did not kill certain types of bacteria. The IP stated the glucometer was sanitized between residents to prevent bloodborne pathogens. During an interview on May 21, 2026, at 10:28 a.m., the DON stated the shared glucometer needed to be disinfected with the appropriate sanitizing wipes. The DON confirmed alcohol swabs were not sufficient to sanitize the glucometer. During a concurrent interview and record review on May 19, 2026, at 4:19 p.m. with the IP, the facility's P&P, titled, Cleaning and Disinfection of Environmental Surfaces, dated April 2025, was reviewed. The P&P indicated, Manufacturers' instructions will be followed for proper use of disinfecting products. The IP stated there was no other facility policy to address the timing or selection of disinfecting wipes for the shared glucometer. A review of the manufacturer's instructions for cleaning and disinfecting the glucometer, titled, Guidelines for Cleaning and Disinfecting the Assure Platinum Meter [facility's glucometer], undated and provided by the IP, indicated: . To minimize the risk of transmitting blood-borne pathogens, the cleaning and disinfecting procedure should be performed as recommended. The meter should be cleaned and disinfected after use on each patient. and .ARKRAY [manufacturer] recommends using these wipes to clean and disinfect the Assure Platinum meter. Clorox Healthcare Bleach Germicidal [kills bacteria and viruses] Wipes. Super Sani-Cloth Germicidal Disposable Wipes. A review of the facility's P&P, titled, Administering Medications, dated April 2019, indicated, Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure dignity was maintained for one of 11 residents reviewed for dignity (Resident 47) when Resident 47's meal tray was not provided at the same time as the other residents seated at her table. This failure had the potential to negatively affect Resident 47's sense of dignity, self-worth, and self-esteem. Findings: On May 18, 2026, at 11:54 a.m., an observation was conducted in the dining room with Resident 47. Resident 47 was seated at a table with two other residents. The other residents were served their meals and began eating. Resident 47 did not receive her meal until 12:05 p.m., approximately eleven minutes later, and was observed looking around while waiting for her meal to arrive. On May 18, 2026, at 12:15 p.m., a concurrent observation and interview were conducted with the Certified Nursing Assistant (CNA 1). CNA 1 stated Resident 47's meal tray had not been ready which had caused the delay in serving her meal with the other residents at the table. CNA 1 further stated that meal trays should be served to all residents at a table at the same time, so residents were not left waiting and watching other eat, in order to preserve resident's dignity. On May 20, 2026, at 10:55 a.m., an interview was conducted with Resident 47. Resident 47 stated she ate lunch in the dining room almost every day and preferred to receive her meal at the same time as the other residents seated at her table. On May 21, 2026, at 9:21 a.m., an interview was conducted with the Registered Dietitian (RD). The RD stated residents seated together were expected to receive their meals at the same time. The RD further stated serving meals separately could make residents feel left out and could negatively affect their sense of self-worth or self-esteem. A review of the facility's Policy and Procedure titled Quality of Life - Dignity, dated August 2009, indicated: .Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Residents are treated with dignity and respect at all times.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident received a prompt response and notification of the grievance investigation findings following submission of a grievance for one of four residents reviewed for grievances (Resident 9). This failure had the potential to leave Resident 9 unaware of whether her grievance had been investigated and addressed, which had the potential to contribute to ongoing dissatisfaction regarding her concerns. Findings: On May 18, 2026, at 3:31 p.m., an interview was conducted with Resident 9 in her room. Resident 9 stated staff and a physician referred to her as a troublemaker. Resident 9 stated she was upset by the comment. Resident 9 stated It's irritating. It makes me mad after a while. Resident 9 stated she had filed a grievance with the Social Services Director (SSD) regarding the physician's comment but had not received any follow-up. Resident 9 further stated the incident occurred a couple of weeks earlier at the nurses' station while she was with another resident. Resident stated she ignored the comment at that time but did not like being called that. A review of Resident 9's record showed she was admitted on [DATE], with diagnoses including depression (mood disorder that causes a persistent feeling of sadness). A review of Resident 9's Minimum Data Set (MDS- an assessment tool), dated April 6, 2026, indicated her Brief Interview for Mental Status (BIMS) score was 14, reflecting intact cognitive function. On May 20, 2026, at 9:15 a.m., an interview was conducted with the SSD. The SSD stated that Resident 9 filed a grievance approximately two months earlier regarding a comment made by the physician. The SSD further stated she informed the physician of the grievance and told him Resident 9 expected an apology. The SSD stated she was unsure whether the physician had apologized to Resident 9. The SSD further stated she did not follow-up on the grievance after speaking with the physician. A review of the Grievance Report Form and Follow-Up/Investigation Report dated March 26, 2026, indicated multiple sections were incomplete including: - Department Manager Filing Follow Up Report: DON, F/U Report date: - Was the complaint/grievance addressed? - Date resident notified of report findings, - By, and Copy of report given to. -The form contained the SSD's signature but no date indicating the completion of the grievance investigation. Further review of Resident 9's medical record indicated no documented evidence that Resident 9 was notified of the findings or outcome of the investigation since the grievance was filed on March 26, 2026. On May 21, 2026, at 12:55 p.m., a follow-up interview was conducted with the SSD. The SSD stated the grievance form was incomplete and stated it was her responsibility to ensure the grievance investigation was completed and documented. The SSD further stated there should have been a follow-up with Resident 9 and that Resident 9 should have been informed of the outcome of the grievance. On May 21, 2026, at 12:58 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated that she was not aware of the grievance and had not participated in the investigation. The DON stated the grievance remained unresolved and Resident 9 had not been informed of any findings or outcome. The DON stated the Social Services was responsible for following up with the resident regarding the physician's response and documenting the investigation. The DON further stated it was important to notify residents of grievance findings and result to ensure the resolution was acceptable to the complainant. The DON stated documentation of grievance investigations was necessary to demonstrate the grievance was investigated, addressed, communicated, and resolved. The DON further stated the facility did not follow its grievance process. The facility's policy titled Grievances/Complaints, Filing, dated 2017, indicated, .the Administrator has delegated the responsibility of grievance and/or complaint investigation to the Grievance Officer who is Social Services. Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings within 5 working days of receiving a grievance and/or complaint. The person filing the grievance and/or complaint on behalf of the resident will be informed (verbally and in writing) of the findings of the investigation.		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to administer one medication as ordered by the prescriber for one of seven residents (Resident 78) during the medication administration observation. This failure resulted in Resident 78 receiving a dose of metoprolol tartrate (generic for Lopressor, a medication to treat high blood pressure) without food which could cause hypotension (low blood pressure which can cause dizziness and fainting). Findings: During a medication pass observation on May 18, 2026, at 3:48 p.m. in the hallway outside of Resident 78's room, Licensed Vocational Nurse 4 (LVN 4) was observed administering four medications to Resident 78. The medications included one tablet of metoprolol tartrate 50 milligrams (mg). LVN 4 gave Resident 78 a cup of water to take with the medications. A review of Resident 78's physician's orders, dated October 13, 2022, indicated Resident 78 had orders for metoprolol tartrate 50 mg by mouth two times a day for hypertension (high blood pressure), take with food. During a concurrent interview and record review on May 18, 2026, at 4:48 p.m. with LVN 4, Resident 78's metoprolol tartrate orders were reviewed. LVN 4 stated Resident 78's metoprolol tartrate orders indicated to give the medication with food. LVN 4 stated he did not give Resident 78 food with the medication because it was too early for dinner. During a telephone interview on May 20, 2026, at 10:50 a.m., the Consultant Pharmacist (CP) stated metoprolol tartrate was recommended to give with food. The CP stated the concern was the blood pressure dropping too low if given without food. During an interview on May 20, 2026, at 11:51 a.m., the Director of Staff Development (DSD) stated if a medication was ordered to take with food, the expectation was the nurse would give the medication with food. The DSD stated Resident 78's metoprolol tartrate should have been given with dinner or with a snack. During an interview on May 21, 2026, at 10:28 a.m., the Director of Nursing (DON) stated Resident 78's metoprolol tartrate should have been given with food. The DON stated the physician's orders were supposed to be followed. A review of the Prescribing Information (PI, detailed description of a medication that is available to clinicians) for metoprolol tartrate tablets, dated January 31, 2024, retrieved from DailyMed, indicated, Metoprolol tartrate tablets should be taken with or immediately following meals. A review of the facility's policies and procedures (P&P), titled, Administering Medications, dated April 2019, indicated, Medications are administered in a safe and timely manner, and as prescribed.		