STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676389	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Matador Health and Rehabilitation Center	805 Harrison St Matador, TX 79244

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure PRN orders for anti-psychotic drugs were limited to 14 days unless the attending physician or prescribing practitioner evaluates the resident beyond 14 days for one (Resident #2) of three residents reviewed for freedom of abuse, in that:The facility failed to stop a psychotropic medication, Lorazepam (an anti-anxiety medication), which was ordered for Resident #2 to be administered PRN after 14 days without the physician's authorization. Resident #2 was administered 12 additional doses without a physician's order.The deficient practice placed residents at risk of being chemically restrained, sedated, and altered mental status.Findings included: Record Review of Resident #2's undated face sheet reflected [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including non-Hodgkin lymphoma, psychotic disorder with hallucinations, major depressive disorder, other specified disorders of brain, acute respiratory failure with hypoxia, hypertension, benign prostatic hyperplasia, intermittent explosive disorder, urinary tract infection, pulmonary embolism, cellulitis, repeated falls, facture of first lumbar vertebra, encounter for fracture with routine healing.Record Review of Resident #2's MDS assessment, dated 7/31/25, reflected a BIMs score of 12 for cognitive awareness for daily decision making, had inattention and disorganized thinking, with hallucinations and delusions, had behavior symptoms directed towards other and himself but not on a daily basis with significantly interferes with the residents care and the residents participation in activities or social interactions, puts others at significant risk for physical injury and significantly disrupts care or living environment, rejected care occurred 1 to 3 days in the look back period, with his current behavior status has worsened since prior assessment. Record review of Resident #2's care plan, dated 1/29/25, reflected resident appears lethargic and had decreased cognition related to disease process leukemia and lymphoma, resident was on a PRN anxiety medication for anxiety, transferred to a behavioral hospital on 7/7/25 for hallucinations, delusions and paranoid behaviors, had delirium or an acute confusional episode on 8/6/25 with change in condition of unknown origin, had a psychosocial well-being problem related to cancer and long term care placement, resident had little or no activity involvement related to disinterest, resident was on EBP precautions for wounds to bilateral feet, resident had current skin issues to right elbow, coccyx, right heel, left heel, and back of left foot, Resident was on Hospice Care - 9/19/25, on narcotic pain medication for air hunger and pain related to end of life care, resident has declined since admission in self-performance and had increase safety concerns, had depression related to disease process lymphoma and depression, and stated he would be better off dead.Record Review of Resident #2's physician's orders, on 8/21/25, reflected the following order:Lorazepam 0.5 mg by mouth every hour as needed for anxiety - start date 8/21/25 - a stop date was not listed.The Lorazepam medication was documented as being administered on the Medication Administration Record on the following dates:September 6, 2025 - one timeSeptember 14, 2025 - one timeSeptember 17, 2025 - three timesSeptember 19, 2025 - one timeSeptember 21, 2025- one timeSeptember 22, 2025 - two timesSeptember 23, 2025 - one timeSeptember 24, 2025 - two times for a total of 12 doses. An observation on 9/23/25 at 10:38 a.m. revealed Resident #2 was asleep in his room in a low bed. (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/25/25 at 10:37 a.m., the DON stated she did not know why Resident #2's PRN lorazepam order was not dropped off after 14 days. The DON stated they talked about psychotropic medications in the morning meeting and stopping PRN medications after 14 days. Record review of the facility's policy titled. Unnecessary Drugs documented it was the policy of this facility to appropriately utilize and monitor the use of medications throughout the tenure of a residents stay. Procedure: The facility will ensure each resident's drug regimen is free from unnecessary drugs. A drug may be considered unnecessary when used:1. In excessive dose (including Duplicate drug therapy: or2. For excessive duration; or3. Without adequate indications for its use; or4. Without adequate monitoring; or5. In the presence of adverse consequences which indicate the does should be reduced; or6. Any combination of the reasons listed above (points 1 - 5) Record review of the facility policy titled, Psychotropic Drugs documented - Procedure: The facility will ensure, through a comprehensive assessment of a resident, the following:4. PRN orders for psychotropic drugs will be limited to 14 days unless the prescriber believes that the medication should be extended past 14 days and has documented their rationale in the medical record including the duration for the PRN order.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food service safety.1. The facility failed to ensure food was properly stored, labeled and dated.2. The facility failed to discard expired food items.These failures could place residents at risk of foodborne illness. Findings included:On 09/23/25 at 10:36 AM an observation of the reach-in refrigerator revealed: Individual jelly packets in rectangular plastic tub with no label or date Individual butter packets in rectangular plastic tub with no label or date Individual ranch dressing packets in rectangular plastic tub with no label or date Individual sour cream packets in rectangular plastic tub with no label or date Individual ketchup packets in rectangular plastic tub with no label or date Individual mustard packets in rectangular plastic tub with no label or date On 09/23/25 at 10:38 AM an observation of the walk-In refrigerator revealed: small steam table pan with plastic bag loosely over the top so white contents (1/4 full) was open to air with no label or date brown plastic tray labeled* roast beef 08/28 and two unopened plastic packages of sliced roast beef. box with one packaged ham and water product. Box dated 08/28 blue plastic tray with two logs of what appeared to be ground meat in original, sealed packaging labeled* ground beef 09/18/25. box of beef patties no date blue plastic tray with what appeared to be large pork loin sealed in original packaging labeled* pork loin 09/18/25 box of eggs no date Plastic tub of potato salad 2/3 gone dated 09/19/25 box cobbler crust dough sheet dated 3-13 plastic opaque square tub labeled* pineapple 9/21 plastic opaque square tub labeled* ham 09/09 appeared to be sliced ham plastic opaque square tub labeled* salsa 09/10 1/3 full plastic opaque square tub of what appeared to be sliced pickles no label, no date 16 oz tub whipped topping no date plastic opaque square tub labeled* shred cheese 09/06 single serving chocolate nutrition shake no date, stick brown substance around the screw top and down the side of the bottle. potato salad tub 1/3 full of brownish liquid labeled* simple syrup 02/23/25 plastic tub of Pimento spread 1/4 full dated 08/21 1 can buttermilk biscuits popped open biscuits dried and flecked with brown spots dated best by 12/16/24 1 can buttermilk biscuits dated best by 12/17/24 small tub of mayonnaise best by 08/23/25 small plastic tub of mild salsa which read consume within 7 days of opening and was dated 07/24/25 with an expiration date of 09/05/25 plastic bottle of siracha best by 03/21/24 metal tray lined with parchment paper layered with sausage links covered with parchment paper open to air labeled for breakfast 09/22/25 zip top plastic bag 1/2 full of what appears to be scrambled eggs no label, no date plastic opaque square tub labeled* pancake mix 9/2025 1/6 full plastic opaque square tub labeled* liquid eggs 9/11 1/4 full box of sausage links open to air On 09/23/25 at 10:56 AM an observation of the pantry revealed the following: 3 boxes of buttermilk biscuit mix with an expiration date of 09/03/25 On 09/23/25 at 11:02 AM an observation of the walk-in freezer revealed the following: one undated plastic bag with two giant pretzels inside with visible round green spots the size of nickels across both pretzels On 09/25/2025 at 10:37 AM an observation of the walk-in refrigerator revealed the following: square opaque plastic tub labeled* shred cheese 09/06; metal tray lined with parchment paper layered with sausage links covered with parchment paper open to air labeled for breakfast 09/25/25; single serving chocolate nutrition shake no date, stick brown substance around the screw top and down the side of the bottle; potato salad tub 1/3 full of brownish liquid labeled* simple syrup 02/23/25; plastic tub of Pimento spread 1/4 full dated 08/21; 1 can buttermilk biscuits popped open biscuits dried and flecked with brown spots dated best by 12/16/24; 1 can buttermilk biscuits dated best by 12/17/24 ; small tub of mayonnaise best by 08/23/25; small plastic tub of mild salsa which read consume within 7 days of opening and was dated 07/24/25 with an expiration date of 09/05/25; plastic bottle of siracha best by 03/21/24; plastic opaque square tub labeled* pineapple 9/21; blue plastic tray with two logs of what appear to be thawed ground meat in original, sealed packaging and one log of what appears to be frozen ground (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meat in original sealed packaging labeled ground beef 09/18/25; brown plastic tray labeled* roast beef 08/28 and two unopened plastic packages of sliced roast beef;*All items noted had a sticky label with a Use By section. This section was blank.During an interview on 09/23/25 at 01:57 PM DM A stated she had trained her kitchen staff in labeling and dating food. She expressed frustration with staff not labeling and dating food correctly. She stated she had taught staff to label leftover food with the date it was made and 6 days later is the expiration date.During an interview on 09/25/25 at 09:59 AM ADON stated residents could get a stomach bug if food in the kitchen was not properly labeled and dated and expired food was not thrown out timely.During an interview on 09/25/25 at 10:03 AM DON stated residents could get ill if food in the kitchen was not properly labeled and dated and expired food was not thrown out timely.During an interview on 09/25/25 at 10:11 AM MDS LVN stated residents could be fed old food if food in the kitchen was not properly labeled and dated and expired food was not thrown out timely. She stated this could affect residents negatively in an unknown way. She was unable to clarify what way residents could be negatively affected.During an interview on 09/25/25 at 10:21 AM ADM stated residents could get something that was expired if food in the kitchen was not properly labeled and dated and expired food was not thrown out timely.During an interview on 09/25/25 at 10:44 AM DA C stated she did not label or date food in the kitchen. She stated her boss was responsible for labeling and dating food. She stated she had not been trained in labeling or dating food. She stated residents could get food poisoning if food in the kitchen was not properly labeled and dated and expired food was not thrown out timely.During an interview on 09/25/25 at 10:47 AM DM B stated the cooks were responsible for labeling and dating food and cleaning expired food out of the refrigerator and pantry. She stated she was trained in labeling and dating food when she received her food safety manager's training. She stated when food arrived in the facility from the delivery truck it was dated the day it was received. DM B stated when she took food out of the freezer to thaw, she made a label and put it on a tray and put the frozen food on the tray in the refrigerator. She stated the label was dated the day she took the food from the refrigerator and use by (date) is 5-6 days from then. She stated food taken out of the freezer was good for 6 days maximum. DM B stated regarding leftovers, We don't usually have any leftover food but if we do we put the date on it and 5 days from there and if not used by then we dump (the leftover food). She stated cooks were responsible for cleaning out the refrigerator. She stated they did not have a specific day or time they cleaned out the refrigerator. DM B stated, The cooks always look (for expired food) usually when we go in there (the refrigerator). She stated leftover food was dated the day it was made and the use by date which was 5-6 days after the day it was made. DM B stated residents could get sick if food in the kitchen was not properly labeled and dated and expired food was not thrown out timely. She stated, They have compromised immune systems anyway, I take that very seriously.During an interview on 09/25/25 at 11:01 AM DM A stated the cook or whoever is there was responsible for labeling and dating food. She stated she had trained kitchen staff on labeling and dating food and discarding expired food, but she did not document the training. She stated food taken from the freezer was labeled the day it was taken from the freezer and a week after that day. DM A stated, It (food taken from the freezer) expires in a week. She stated leftover food was dated the day it was made and 2 days after that which was the use by date. She stated residents could be served spoiled food if food in the kitchen was not properly labeled and dated and expired food was not thrown out timely.Record review of an undated facility policy titled Storage of Food in Refrigeration revealed the following: . 4. All containers must be labeled with the contents and date food item was placed in storage. 5. Previously cooked foods can be held in refrigeration . for 3 days-being discarded by day 4.Record review of an undated facility policy titled Dry Storage and Supplies revealed no mention of expired foods.Record review of the 2022 Food Code U.S Food and Drug Administration revised January 18th 2023 revealed the following: . Food Labels . Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identify statement; . Food Storage Containers, Identified with Common Name of Food. The mistaken use of (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	food from unlabeled containers could result in chemical poisoning. Based on a predictive growth curve modeling program for Listeria monocytogenes, ready-to-eat, time/temperature control for safety food may be kept . (41oF) a total of 7 days. Food which is prepared and held, or prepared, frozen, and thawed must be controlled by date marking to ensure its safety based on the total amount of time it was held at refrigeration temperature, and the opportunity for Listeria monocytogenes to multiply, before freezing and after thawing. Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date. A date marking system may be used which places information on the food, such as on an overwrap or on the food container, which identifies the first day of preparation, or alternatively, may identify the last day that the food may be sold or consumed on the premises.

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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 observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights and that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #24) of 12 residents reviewed for comprehensive care plans.The facility failed to include Resident #24's AVAPS machine in her care plan.This failure could lead to residents not receiving needed care and/or receiving improper care/treatment.Findings Included:Record review of Resident #24's admission record dated 09/24/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, heart failure and respiratory failure.Record review of Resident #24's MDS front sheet in the EHR revealed her last annual MDS had an ARD of 12/27/24.Record review of Resident #24's quarterly MDS completed on 09/19/25 revealed a BIMS score of 15 which indicated intact cognition. Section J Health Conditions revealed Resident #24 had no issue with shortness of breath. Section O Special Treatments, Procedures, and Programs revealed Resident #24 utilized a non-invasive mechanical ventilator while a resident.Record review of Resident #24's care plan completed on 07/08/25 revealed no mention of her AVAPS machine. She was noted to receive O2 therapy as needed to maintain O2 saturation at 90% or higher. The goal was: Resident will have proper oxygenation through the review date. The intervention was: Resident will voice concerns related to breathing to nurse on duty. Resident #24 was noted to have shortness of breath. One of the goals was: [Resident #1] will have no complications related to SOB through the review date.Record review of Resident #24's Order Summary dated 09/24/25 revealed the following order with corresponding start date:01/08/25 AVAPS to be worn at HS and PRN to improve respiratory function. every night shift for sleep apnea (common condition in which breathing stops and restarts many times while sleeping, can result in body not getting enough oxygen)Record review of Resident #24's TAR from 06/24/25 to 09/24/25 revealed she wore her AVAPS the following dates:06/02/25-07/04/25,07/07/25-07/13/25,07/15/25-07/20/25,07/23/25-07/26/25,07/28/25-08/02/25,08/04/25 and09/09/25-09/23/25.During an observation and interview on 09/23/25 at 11:28 AM Resident #24 had an AVAPS machine on her bedside table. She stated she used the AVAPS machine at night to keep from having a buildup of CO2 in her lungs.During an interview and observation on 09/24/25 at 03:04 PM Resident #24's AVAPS machine was on her bedside table. Resident #24 stated she used the AVAPS machine every night since her last trip to the hospital. She could not recall the date of her trip to the hospital. She stated the AVAPS machine seemed to be working as her O2 saturations had been anywhere from 90-100 percent.During an interview on 09/25/25 at 09:51 AM CNA D stated Resident #24 had her AVAPS machine since CNA D began working for the facility in March of 2025.During an interview on 09/25/25 at 09:54 AM LVN E stated Resident #24 had had her AVAPS machine for about a year. She stated she turned the machine off in the mornings for Resident #24 because Resident #24 could not reach the button. LVN D stated MDS LVN and ADON were responsible for care plans. She stated she did not think an incomplete care plan would negatively affect resident care. LVN E stated, I don't go off of that (care plan) I go off of the orders.During an interview on 09/25/25 at 09:59 AM ADON stated she and MDS LVN did resident care plans as a team. She stated Resident #24's AVAPS machine should be in her care plan, and she was not sure why it was not. ADON stated she did not think having an incomplete care plan would negatively impact a resident's care.During an interview on 09/25/25 at 10:03 AM DON stated she and ADON were responsible for care plans. She stated she was shocked Resident #24's AVAPS machine was not in her care plan. She stated at the last care plan conference they discussed Resident #24's reluctance to use her AVAPS machine every day as ordered with Resident #24's family member. She stated there was not a negative outcome for a (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident if a care plan was incomplete.During an interview on 09/25/25 at 10:11 AM MDS LVN stated she and ADON were responsible for care plans. She stated new orders for a resident should be reflected in that resident's care plan. She stated she did not think a resident's care would be negatively impacted by an incomplete care plan.During an interview on 09/25/25 at 10:21 AM ADM stated the nursing team was responsible for completing care plans. She stated ADON did the bulk of the work on care plans. ADM stated a resident's care plan should be updated to reflect new physician's orders. Regarding an incomplete care plan having a negative effect on resident care, ADM stated, I don't feel like that because it is just not something that is utilized for actual resident care.Record review of an undated facility policy titled Comprehensive Care Plans revealed the following: . 1. The facility will develop and implement a comprehensive person centered care plan for each resident, . to meet a resident' [sic] medical, nursing, . needs that are identified in the comprehensive assessment. 2. The comprehensive care plan will describe the following: a. The services that are to be furnished to attain the resident's highest practicable physical, mental, and psychosocial well-being .Record review of an undated facility policy titled Continuous Positive Airway Pressure (CPAP) and Bilevel Positive Airway Pressure (BiPAP0, Non-Invasive Ventilatory Support revealed the following: . The Facility ensures adequate staff and competency for the provision of non-invasive ventilatory support modalities, . The Facility establishes policy to ensure safe and uniform standards of practice for the application of NIV in adult patients and residents. 4. A licensed staff member with demonstrated competency with NIV treatment modalities documents: . g. Care plan, including: i. Type of equipment and settings ii. When to administer .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 (Resident #8) of 12 residents reviewed for respiratory care.The facility failed to ensure Resident #8 received O2 via NC at the rate of 2-3 lpm as ordered by her physician.This failure could place residents who receive oxygen at an increased risk of hypercapnia (too much carbon dioxide in the blood), pulmonary oxygen toxicity (damage to the lung lining tissues and air sacs), hypoxemia (low levels of oxygen in the blood, decreasing the oxygen supply to vital organs), and shortness of breath.Findings Included:Record review of Resident #8's admission record dated 09/23/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, congestive heart failure (a progressive heart disease that affects the pumping action of the heart muscles resulting in shortness of breath and fatigue), chronic respiratory failure (respiratory system fails in gas exchange function), pulmonary hypertension due to lung diseases and hypoxia (below-normal level of oxygen in your blood, specifically in the arteries. Hypoxemia is a sign of a problem related to breathing or circulation, and may result in various symptoms, such as shortness of breath), acute and chronic respiratory failure (respiratory system fails in gas exchange function) with hypoxia (below-normal level of oxygen in your blood, specifically in the arteries. Hypoxemia is a sign of a problem related to breathing or circulation, and may result in various symptoms, such as shortness of breath), and acute pulmonary edema (sudden buildup of fluid in the lungs).Record review of Resident #8's quarterly MDS completed on 09/11/25 revealed a BIMS score of 8 which indicated moderately impaired cognition. Section J Health Conditions revealed Resident #8 had shortness of breath with exertion and when lying flat. Section O Special Treatments, Procedures, and Programs revealed Resident #8 received O2 therapy while a resident.Record review of Resident #8's care plan completed 09/22/25 revealed a focus area of, Resident is on oxygen therapy to maintain o2 saturation at 90% or greater. The goal was, Resident will be free of illness related to low oxygen saturation. The intervention was, Oxygen administered as prescribed. The care plan revealed a focus area of, [Resident #8] has altered respiratory status/difficulty breathing r/t allergies, CHF and is Oxygen dependent. The interventions were to Administer medication as ordered and Keep O2 via nasal cannula on to maintain O2 level.Record review of Resident #8's order summary dated 09/23/25 revealed the following order with corresponding start date:11/18/22 Oxygen at 2-3 L/min via NC to keep O2 sats 90 or higher. every shiftRecord review of Resident #8's TAR from June 25th to September 25th revealed she received O2 therapy every day.During an observation on 09/23/25 at 12:13 PM Resident #8 was seated in her wheelchair receiving O2 via NC at 3.5 lpm. She appeared to get breathless while speaking, pausing often and closing her eyes and breathing through pursed lipsDuring an observation on 09/24/25 at 09:41 AM Resident #8 was seated in her wheelchair receiving O2 via NC at 3.5 lpm.During an observation on 09/24/25 at 03:00 PM Resident #8 was lying on her back on her bed receiving O2 via NC at 3.5 lpm.During an interview on 09/25/25 at 09:51 AM CNA D stated nurses were responsible for setting flow rates on oxygen concentrators.During an interview on 09/25/25 at 09:54 AM LVN E stated nurses were responsible for setting flow rates on O2 concentrators. She stated the physician's order for O2 determined flow rate. She stated the goal was to keep the flow rate set as low as possible while keeping the resident's O2 saturation in the range spelled out by the order. LVN E stated if a resident received O2 at higher rates than ordered by the physician, It could decrease their respiratory drive.During an interview on 09/25/25 at 09:59 AM ADON stated nurses were responsible for setting flow rates on O2 concentrators. She stated nurses referred to physician's orders for the flow rate. ADON stated a resident could have over oxygenation if they received O2 at higher rates (continued on next page)

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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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	than ordered.During an interview on 09/25/25 at 10:03 AM DON stated nurses were responsible for setting flow rates on O2 concentrators. She stated the nurses referred to physician's orders to determine the correct flow rate. DON stated as an ER nurse she did not think there could be a negative outcome for a resident receiving O2 at higher rates than ordered.During an interview on 09/25/25 at 10:11 AM MDS LVN stated nurses were responsible for setting flow rates on O2 concentrators. She stated the flow rate was based on physician orders and O2 saturation. MDS LVN stated a resident could have CO2 retention if they received O2 at higher rates than it was ordered.During an interview on 09/25/25 at 10:21 AM ADM stated nurses were responsible for setting flow rates on O2 concentrators. She stated the flow rate was based off of the physician's order. ADM stated receiving O2 at higher rates than ordered could knock out their (residents') drive to breath.Record review of facility policy titled Oxygen Administration and dated March 2004 revealed the following: . The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan .