STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676343	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Waco	9101 Panther Way Waco, TX 76712

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible to prevent accidents for 1 (Resident #1) of 5 residents reviewed for accidents and hazards.The facility failed to label a large plastic bottle of purified water, which was kept in Resident #1's room, as hummingbird water, which RN A poured into Resident #1's CPAP water reservoir on 03/09/2026. This failure could place residents at risk of infection or exposure to fungus.Findings included:Review of Resident #1's comprehensive MDS assessment dated [DATE] reflected an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of unspecified dementia, and cognitive communication deficit. Resident #1 had a BIMS score of 07-indicating severe cognitive impairment.Review of Resident #1's comprehensive care plan dated 03/11/2026 reflected the resident required use of a CPAP machine at bedtime for diagnosis of obstructive sleep apnea as evidenced by a sleep study conducted on 12/10/2025. The interventions included: 3/11/25-Obtain vital signs every 4 hours for 7 days. Licensed nurse to perform and document respiratory assessment assessing for signs of infection every 4 hours for 7 days; Respiratory Therapist to visit and assess resident every day for 7 days. Fill CPAP reservoir with distilled water only every night. Clean [CPAP] mask and tubing with antibacterial soap, rinse with water until clearand hang to dry weekly on Monday mornings and as needed.Review of Resident #1's sleep study report dated 12/10/2025 revealed a respiratory analysis of a total of 139 obstructive events of which 111 were obstructive apneas (partial or complete blockage of the upper airway), 28 were hypopneas (shallow breaths). The respiratory arousal index was 44.4/hr (44.4 times per hour that the brain is aroused due to respiratory events). Her baseline oxygen saturation (percentage of hemoglobin in the blood that carries oxygen) was 92% while awake. The lowest de-saturation (decrease in the oxygen saturation of the blood) was 73%. A new diagnosis was reported on this date of Obstructive sleep apnea with an order for nightly use of CPAP.Review of Resident #1's physician orders active as of 03/12/2026 revealed an order for ?[CPAP] to be worn at night. On at HS, off in AM Settings: 7cmH20 at bedtime.' Ordered on 01/07/2026.Review of facility self-report undated, revealed, Resident's [family member] notified the respiratory therapist that the night nurse had filled the resident's CPAP reservoir with hummingbird water. This bottle of sugar water was contained in a disposable plastic water bottle with the label purified water. The water was light yellow in color. Upon report of this occurring the respiratory therapist immediately performed a respiratory assessment with no deviations from baseline noted. On 03/11/26, the resident attended a pulmonology appointment, accompanied by her RP. Upon return, her RP reported to the respiratory therapist that the pulmonologist had stated the occurrence was very, very dangerous and the resident would need to be monitored closely for a bacterial infection and that the CPAP would need to be replaced or sterilized.In an interview on 03/12/2026 at 10:30 AM with Resident #1's RP, she stated that the bottle of water used to refill the CPAP machine on 03/09/2026 by RN A was a jug of hummingbird water, which was a mixture of tap water and granulated sugar, that was filled around July 2025 by the family, and the jug was kept sitting underneath the residents refrigerator near the (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bird seed in her room.Observation of an AEM video timestamped 03/09/2026 at 6:05:56 PM, revealed RN A looking near Resident #1's bed and saying where is your water at? She handed Resident #1 her CPAP mask to apply to her face and continued looking for distilled water. RN A then turned around and could be heard saying, oh there it is, and was seen bending down and picking up a bottle of water that had a blue label from an area beneath where the AEM was located. She took the bottle over to Resident #1's nightstand and poured the water into the CPAP machine, returned the bottle of water to the place she found it, and left the room. Observation of an AEM video timestamped 03/09/2026 at 6:25:49 PM, LVN B was observed entering Resident #1's room, removed the CPAP mask off Resident #1, and began looking at the CPAP machine.In an interview on 03/12/2026 at 12:12 PM with RN A, she stated she had been working at the facility for 2 years and worked night shift. She stated that when she went into Resident #1's room on 03/09/2026, she noticed the resident was asleep in bed. She woke up the resident, had her put her CPAP mask on and noticed the water reservoir on the CPAP was empty. She stated she did not see the distilled water bottle that was normally on Resident #1's nightstand or floor next to it. She stated she found a labeled bottle of purified water under the resident's refrigerator, and used it because the water looked clear and that the restroom light was on in the room and she could see adequately. She stated she was then told by the nurse at the nurses station that the water she had used was hummingbird food, and that there were bottles of distilled water in the medication room. She stated she had tried to clean out the water reservoir with water and tissues. She stated that normally the distilled water was kept in the resident's room, and if there was not any in the room, it would be in the medication room, and last time she went into the medication room there was no distilled water. She stated that purified water was not the same as distilled water, and that she thought it was okay to use because at least it was not tap water. She stated that she did not recall receiving specific training at this facility on CPAP use. She stated that she was supposed to clean the mask, the hose, and the reservoir after every use. She stated she could not detach the reservoir from Resident #1's machine in order to clean it. She stated the expectations were that the mask and hoses were to be cleaned after every use and to be air dried when the resident was awake. She stated that the machine was to be cleaned with soap and water and rinsed thoroughly. She stated that she cleaned Resident #1's with a tissue and water, because she was just doing what she could until she was told not to take care of the Resident #1 anymore. She stated that she would not do anything to put Resident #1 harms way. She stated she was very emotional after this incident, and she was suspended pending a facility investigation . She stated that a negative outcome could be that the resident could get sick.In an observation and interview on 03/12/2026 at 12:38 PM, Resident #1 was lying in bed in her room. She stated that she did not wear her CPAP often, and she did not recall the incident with RN A from the other night.In an interview on 03/12/2026 at 2:08 PM with LVN B, she stated that she normally did not work Resident #1's hall, so she was not aware the hummingbird water was kept in her room. She stated that she knew Resident #1 had recently started using the CPAP machine. She stated that she got a phone call from Resident #1's RP at the nurse's desk, and the RP told LVN B that RN A had poured hummingbird water into Resident #1's CPAP. LVN B stated she then went into Resident #1's room and took the CPAP off the resident, and took the hummingbird water to the medication room. She stated the room was a little dark, and you would have had to turn on a light to see better, but the water did look discolored to her. She stated that the jug of water RN A used was not the type of jug they usually used for CPAP machines, but that they used a milk jug type. She stated that she believed this incident was just a mistake and was not a pattern for RN A. She didn't know of any negative outcome that could happen.In an interview on 03/12/2026 at 2:23 PM with the RT, she stated she was familiar with Resident #1 because she had hooked up the CPAP machine when it first arrived for Resident #1. She stated that a CPAP machine was for oxygenation, it would help a patient that had, from mild to severe (Resident #1 had severe she stated), sleep apnea, and the humidified water would be going into one's lungs. She stated the water to be used in the humidifier was sterile or distilled. She stated that she (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not know what a mixture of tap water and granulated sugar would do to the lungs by inhaling it, but it was dangerous to have in the machine, because it could coat the machine. It could, over time, also cause bacteria to build up in the machine, which could potentially cause a bacterial infection in the lungs, if breathed in over a long period of time. She stated that breathing complications would only occur if bacteria were breathed in for a long period of time, like a whole night. The RT stated that she personally cleaned Resident #1's CPAP machine on 03/09/2026, with soap and water. She stated that Resident #1's pulmonary doctor told the facility to take the CPAP out of service. She stated that it was her understanding Resident #1 had been without her CPAP for 2 nights. She stated that negative outcomes could be that Resident #1's oxygen could have dropped, she could have had long pauses of not breathing during her sleep, potentially be very drowsy during the day. She stated that normally the vitals were done by the nurses, but she would be doing them until next week for Resident #1. She stated that she would be responsible for doing respiratory assessments daily, for the next 7 days, which were to include: checking Resident #1's heartrate, breath sounds (respirations), and an oxygen check, and all of the assessments she had conducted so far had no abnormal findings. She stated that she last would have done CPAP/BIPAP training in December at this facility. In an interview on 03/12/2026 at 3:37 PM with the MD, he stated that Resident #1 went to a pulmonary appointment 2 days after the incident. He stated that the facility did an x-ray and it came back normal. He stated that the facility informed him of how the incident happened. He stated that if Resident #1 would not have gone to the pulmonary doctor, and if the facility had continuously administered that water mixture it could build up in the machine, and the biggest risk would be that the residue would be getting stuck in the chamber. He stated that he thought Resident #1 being administered that mixture of water 1 or 2 times was not dangerous, but that the facility would need to monitor the resident for fever, and signs or symptoms of infection, he stated he would be worried if the machine got colonized and not cleaned out. In an interview on 03/12/2026 at 3:48 PM with the FNP, who saw Resident #1 in her clinic on 03/11/2026, stated she had not read any scholarly articles on this matter. She stated the concern she had was how long this water mixture had been used, or if this was the first time. She stated that she told the family to look out for any signs of infection (cough, fever). She stated she supposed there could be potential for infection or risk for fungus if continued use over a period of time. She stated that when she saw Resident #1, she did not see anything out of the resident's normal baseline, there were no signs of distress, or coughing, and if she had heard anything abnormal on her lungs, an x-ray that would have been the first thing she obtained. She told the family that Resident #1 needed to be monitored.In an interview on 03/13/2026 at 10:43 AM with the DON, she stated that the facility's investigation into the incident with Resident #1 had not been completed yet, but that that they had gotten the statement from RN A, and RN A was suspended pending completion of the investigation. She stated the incident was not intentional, the hummingbird water bottle was not clearly labeled, and from her observation, the water was cloudy but not necessarily a color. She stated that she did not think it was malicious. She stated that the facility did use that same bottle when they obtained them from the supplier, the milk jugs were from the grocery store, when they ran out of supplier water. She stated that she was not aware of how long the bottle of hummingbird water had been in Resident #1's room. She stated that they would start focusing on potential room hazards during angel rounding. She stated that this was such an off thing that she was unsure what negative outcomes could occur, unless this substance had bee administered to Resident #1 for an extended period of time. She stated that because of the type of substance it was, she felt that it would have messed up the machine before it would have hurt the resident. She stated to the best of her knowledge RN A had not used that bottle of hummingbird water before this incident. She stated that the resident went 1 night without the CPAP after it was taken out of service on 03/11/2026. The new machine was delivered to the facility on [DATE], and Resident #1 used it that night.Review of the facility's policy titled CPAP/BiPAP Support, undated, reflected, Humidifier water- Empty the humidifier chamber in the morning, rinse it, and leave it empty during the day. Refill it with fresh distilled water in the evening before using it.

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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 a resident who needed respiratory care, was provided such care, consistent with professional standards of practice for 1 (Resident #1) of 5 residents reviewed for respiratory care.RN A knowingly used a bottle of water labeled purified water instead of using distilled water, as she was trained to use by the facility to fill Resident #1's CPAP reservoir on 03/09/2026.RN A failed to follow the care plan and training to use only distilled water resulting in Resident #1's CPAP air being humidified with sugar water and Resident #1 being without the use of her CPAP on 03/11/2026.These failures could place residents at risk of receiving incorrect or inadequate treatment and could result in exposure to fungus and/or infection. Findings included:Review of Resident #1's comprehensive MDS assessment dated [DATE] reflected an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of unspecified dementia, and cognitive communication deficit. Resident #1 had a BIMS score of 07-indicating severe cognitive impairment.Review of Resident #1's comprehensive care plan dated 03/11/2026 reflected the resident required use of a CPAP machine at bedtime for diagnosis of obstructive sleep apnea as evidenced by a sleep study conducted on 12/10/2025. The interventions included: 3/11/25-Obtain vital signs every 4 hours for 7 days. Licensed nurse to perform and document respiratory assessment assessing for signs of infection every 4 hours for 7 days; Respiratory Therapist to visit and assess resident every day for 7 days. Fill CPAP reservoir with distilled water only every night. Clean [CPAP] mask and tubing with antibacterial soap, rinse with water until clearand hang to dry weekly on Monday mornings and as needed.Review of Resident #1's sleep study report dated 12/10/2025 revealed a respiratory analysis of a total of 139 obstructive events of which 111 were obstructive apneas (partial or complete blockage of the upper airway), 28 were hypopneas (shallow breaths). The respiratory arousal index was 44.4/hr (44.4 times per hour that the brain is aroused due to respiratory events). Her baseline oxygen saturation (percentage of hemoglobin in the blood that carries oxygen) was 92% while awake. The lowest de-saturation (decrease in the oxygen saturation of the blood) was 73%. A new diagnosis was reported on this date of Obstructive sleep apnea with an order for nightly use of CPAP.Review of Resident #1's physician orders active as of 03/12/2026 revealed an order for ?[CPAP] to be worn at night. On at HS, off in AM Settings: 7cmH20 at bedtime.' Ordered on 01/07/2026.Review of facility self-report undated, revealed, Resident's [family member] notified the respiratory therapist that the night nurse had filled the resident's CPAP reservoir with hummingbird water. This bottle of sugar water was contained in a disposable plastic water bottle with the label purified water. The water was light yellow in color. Upon report of this occurring the respiratory therapist immediately performed a respiratory assessment with no deviations from baseline noted. On 03/11/26, the resident attended a pulmonology appointment, accompanied by her RP. Upon return, her RP reported to the respiratory therapist that the pulmonologist had stated the occurrence was very, very dangerous and the resident would need to be monitored closely for a bacterial infection and that the CPAP would need to be replaced or sterilized.In an interview on 03/12/2026 at 10:30 AM with Resident #1's RP, she stated that the bottle of water used to refill the CPAP machine on 03/09/2026 by RN A was a jug of hummingbird water, which was a mixture of tap water and granulated sugar, that was filled around July 2025 by the family, and the jug was kept sitting underneath the residents refrigerator near the bird seed in her room.Observation of an AEM video timestamped 03/09/2026 at 6:05:56 PM, revealed RN A looking near Resident #1's bed and saying where is your water at? She handed Resident #1 her CPAP mask to apply to her face and continued looking for distilled water. RN A then turned around and could be heard saying, oh there it is, and was seen bending down and picking up a bottle of water that had a blue label from an area beneath where the AEM was located. She took the bottle over to Resident #1's nightstand and poured the water into the CPAP machine, returned the bottle of water to (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the place she found it, and left the room. Observation of an AEM video timestamped 03/09/2026 at 6:25:49 PM, LVN B was observed entering Resident #1's room, removed the CPAP mask off Resident #1, and began looking at the CPAP machine.In an interview on 03/12/2026 at 12:12 PM with RN A, she stated she had been working at the facility for 2 years and worked night shift. She stated that when she went into Resident #1's room on 03/09/2026, she noticed the resident was asleep in bed. She woke up the resident, had her put her CPAP mask on and noticed the water reservoir on the CPAP was empty. She stated she did not see the distilled water bottle that was normally on Resident #1's nightstand or floor next to it. She stated she found a labeled bottle of purified water under the resident's refrigerator, and used it because the water looked clear and that the restroom light was on in the room and she could see adequately. She stated she was then told by the nurse at the nurses station that the water she had used was hummingbird food, and that there were bottles of distilled water in the medication room. She stated she had tried to clean out the water reservoir with water and tissues. She stated that normally the distilled water was kept in the resident's room, and if there was not any in the room, it would be in the medication room, and last time she went into the medication room there was no distilled water. She stated that purified water was not the same as distilled water, and that she thought it was okay to use because at least it was not tap water. She stated that she did not recall receiving specific training at this facility on CPAP use. She stated that she was supposed to clean the mask, the hose, and the reservoir after every use. She stated she could not detach the reservoir from Resident #1's machine in order to clean it. She stated the expectations were that the mask and hoses were to be cleaned after every use and to be air dried when the resident was awake. She stated that the machine was to be cleaned with soap and water and rinsed thoroughly. She stated that she cleaned Resident #1's with a tissue and water, because she was just doing what she could until she was told not to take care of the Resident #1 anymore. She stated that she would not do anything to put Resident #1 harms way. She stated she was very emotional after this incident, and she was suspended pending a facility investigation . She stated that a negative outcome could be that the resident could get sick.In an observation and interview on 03/12/2026 at 12:38 PM, Resident #1 was lying in bed in her room. She stated that she did not wear her CPAP often, and she did not recall the incident with RN A from the other night.In an interview on 03/12/2026 at 2:08 PM with LVN B, she stated that she normally did not work Resident #1's hall, so she was not aware the hummingbird water was kept in her room. She stated that she knew Resident #1 had recently started using the CPAP machine. She stated that she got a phone call from Resident #1's RP at the nurse's desk, and the RP told LVN B that RN A had poured hummingbird water into Resident #1's CPAP. LVN B stated she then went into Resident #1's room and took the CPAP off the resident, and took the hummingbird water to the medication room. She stated the room was a little dark, and you would have had to turn on a light to see better, but the water did look discolored to her. She stated that the jug of water RN A used was not the type of jug they usually used for CPAP machines, but that they used a milk jug type. She stated that she believed this incident was just a mistake and was not a pattern for RN A. She didn't know of any negative outcome that could happen.In an interview on 03/12/2026 at 2:23 PM with the RT, she stated she was familiar with Resident #1 because she had hooked up the CPAP machine when it first arrived for Resident #1. She stated that a CPAP machine was for oxygenation, it would help a patient that had, from mild to severe (Resident #1 had severe she stated), sleep apnea, and the humidified water would be going into one's lungs. She stated the water to be used in the humidifier was sterile or distilled. She stated that she did not know what a mixture of tap water and granulated sugar would do to the lungs by inhaling it, but it was dangerous to have in the machine, because it could coat the machine. It could, over time, also cause bacteria to build up in the machine, which could potentially cause a bacterial infection in the lungs, if breathed in over a long period of time. She stated that breathing complications would only occur if bacteria were breathed in for a long period of time, like a whole night. The RT stated that she personally cleaned Resident #1's CPAP machine on 03/09/2026, with soap and water. She stated that (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's pulmonary doctor told the facility to take the CPAP out of service. She stated that it was her understanding Resident #1 had been without her CPAP for 2 nights. She stated that negative outcomes could be that Resident #1's oxygen could have dropped, she could have had long pauses of not breathing during her sleep, potentially be very drowsy during the day. She stated that normally the vitals were done by the nurses, but she would be doing them until next week for Resident #1. She stated that she would be responsible for doing respiratory assessments daily, for the next 7 days, which were to include: checking Resident #1's heartrate, breath sounds (respirations), and an oxygen check, and all of the assessments she had conducted so far had no abnormal findings. She stated that she last would have done CPAP/BIPAP training in December at this facility. In an interview on 03/12/2026 at 3:37 PM with the MD, he stated that Resident #1 went to a pulmonary appointment 2 days after the incident. He stated that the facility did an x-ray and it came back normal. He stated that the facility informed him of how the incident happened. He stated that if Resident #1 would not have gone to the pulmonary doctor, and if the facility had continuously administered that water mixture it could build up in the machine, and the biggest risk would be that the residue would be getting stuck in the chamber. He stated that he thought Resident #1 being administered that mixture of water 1 or 2 times was not dangerous, but that the facility would need to monitor the resident for fever, and signs or symptoms of infection, he stated he would be worried if the machine got colonized and not cleaned out. In an interview on 03/12/2026 at 3:48 PM with the FNP, who saw Resident #1 in her clinic on 03/11/2026, stated she had not read any scholarly articles on this matter. She stated the concern she had was how long this water mixture had been used, or if this was the first time. She stated that she told the family to look out for any signs of infection (cough, fever). She stated she supposed there could be potential for infection or risk for fungus if continued use over a period of time. She stated that when she saw Resident #1, she did not see anything out of the resident's normal baseline, there were no signs of distress, or coughing, and if she had heard anything abnormal on her lungs, an x-ray that would have been the first thing she obtained. She told the family that Resident #1 needed to be monitored.In an interview on 03/13/2026 at 10:43 AM with the DON, she stated that the facility's investigation into the incident with Resident #1 had not been completed yet, but that that they had gotten the statement from RN A, and RN A was suspended pending completion of the investigation. She stated the incident was not intentional, the hummingbird water bottle was not clearly labeled, and from her observation, the water was cloudy but not necessarily a color. She stated that she did not think it was malicious. She stated that the facility did use that same bottle when they obtained them from the supplier, the milk jugs were from the grocery store, when they ran out of supplier water. She stated that she was not aware of how long the bottle of hummingbird water had been in Resident #1's room. She stated that they would start focusing on potential room hazards during angel rounding. She stated that this was such an off thing that she was unsure what negative outcomes could occur, unless this substance had bee administered to Resident #1 for an extended period of time. She stated that because of the type of substance it was, she felt that it would have messed up the machine before it would have hurt the resident. She stated to the best of her knowledge RN A had not used that bottle of hummingbird water before this incident. She stated that the resident went 1 night without the CPAP after it was taken out of service on 03/11/2026. The new machine was delivered to the facility on [DATE], and Resident #1 used it that night.Review of the facility's policy titled CPAP/BiPAP Support, undated, reflected, Humidifier water- Empty the humidifier chamber in the morning, rinse it, and leave it empty during the day. Refill it with fresh distilled water in the evening before using it.