STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455804	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at San Knoll	5757 N. Knoll San Antonio, TX 78240

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 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 residents were treated with respect and dignity and to provide care for each resident in a manner and in an environment that promotes, maintains, or enhances his or her quality of life 2 of 2 (Resident #1 and Resident #2) residents reviewed for resident rights. The facility failed to provide a dignified and respectful dining experience for Resident #1 and Resident #2 on 6/10/2026 during feeding assistance by standing in front of them. This failure could result in the loss of dignity of residents and decreased quality of life. The findings included: During an observation on 6/10/2026 at 1:09 PM, two residents (Resident #1 and Resident #2) were observed being fed by CNA A and LVN B at the nurse's station. CNA A was standing in front of Resident #1 who was seated in a chair. LVN B was standing in front of Resident #2 who was seated in a chair. During an interview on 6/10/2026 at 1:32 PM, CNA A said feeding assistance was a part of his daily responsibilities. He said that he received training on assisting residents with feeding in another facility. He revealed he received orientation training when he was hired but was not sure if it included training in assisting residents with feeding. He stated that he did not sit with the resident because he was not aware that a chair was available. He said that standing with the resident could impact the resident because food could be dropped. During an interview on 6/10/2026 at 1:32 PM, LVN B revealed she had received feeding assistance training in orientation. She said that she knew the proper position for assisting residents with feeding was to sit with them at face level. She said that they are normally assisting residents with feeding in the dining room but that they were doing work on it today and we do what we can with the resources we have. She said the impact to the resident was It's like a dignity thing. If you're standing, it may seem like we are rushing them. During an interview on 6/11/2026 at 2:06 PM, the DON said that feeding assistance training was a part of the nursing staff training to ensure competency. She said, They shouldn't be standing. They should be sitting with the resident. I conducted an in-service to make sure the appropriate diet was served, the residents ate without any issues and staff were feeding one person at a time. Hands should be sanitized. She said the impact to a resident was a dignity issue. She said, When seated you can see better, it's safer that way. Record review of the facility's policy titled, Dignity, revised February 2021, stated: Policy StatementEach resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.Policy Interpretation and Implementation1. Residents are treated with dignity and respect at all times.5. When assisting with care, residents are supported in exercising their rights. For example, residents are:e. provided with a dignified dining experience.

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