STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455484	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Juan Nursing Home, Inc.	300 N Nebraska Ave. San Juan, TX 78589

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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that care and services were provided by qualified persons in accordance with the written plan of care for 1 or 3 residents (Resident #1) reviewed for qualified persons.The facility failed to provide direct supervision to a student nurse while the student nurse administered a gastrostomy tube bolus feeding. This failure could place residents with a G-tube at risk of abdominal discomfort, aspiration, and decreased quality of life.Findings included: Record review of Resident #1's admission record dated 06/17/26 revealed an original admission date of 02/01/22 and admission date of 04/08/24. The diagnoses included: dysphagia (trouble swallowing), anorexia (loss or lack of appetite), Encounter for attention to gastronomy (routine care, maintenance, changing, or fixing a clogged or dislodged G-tube (a flexible feeding tube surgically placed through the abdomen directly into the stomach)), and gastro-esophageal reflux disease (when stomach acid flows back up into the esophagus and causes heartburn). Record review of Resident #1's Care Plan dated 02/02/22 revealed Resident #1 required the use of a feeding tube.Record review of Resident #1's MDS assessment dated [DATE] revealed an additional diagnosis of gastroparesis (a condition in which the muscles in the stomach did not move food).Record review of Resident #1's Order Summary Report dated 06/18/26, revealed an order, dated 04/10/24, enteral feed order, every day shift and night shift The order indicated to check residual (use a 60 mL syringe to aspirate (pulling back on the plunger) and measure the remaining liquid in a person's stomach): The order indicated if there was more than 100 mL of stomach content, return gastric contents to the stomach, withhold medication and notify the physician. This Order Summary Report also revealed an order dated 04/08/24, enteral feed order four times a day, bolus feedings (a method of delivering liquid nutrition or formula directly into the stomach through a feeding tube using a syringe): Jevity 1.2 (nutrient-packed liquid meal replacement) bolus (a method of delivering liquid nutrition directly into the stomach through a feeding tube using a syringe), 4 times a day.Resident #1 was not interviewed because resident had expired.During an interview on 06/16/26 at 9:29 AM, Resident #1's family member stated they observed Resident #1 received a bolus feeding from a student nurse. Resident #1's family member stated the student nurse, name unknown, entered Resident #1's room with feeding supplies in hand. Resident #1's family member stated the student nurse was waiting for the instructor to enter the room to proceed with the bolus feeding. Resident #1's family member stated the student nurse proceeded to administer the bolus feeding without the instructor or a nurse present. Resident #1's family member stated the student nurse did not check for residuals prior to administering the feeding. Resident #1 family member stated that by the time the student nurse was finishing with the feeding, the instructor showed up and assisted the student nurse with the last portion of the formula and water input. Resident #1's family member stated that it was her understanding that all student nurses had to be supervised by the Clinical Instructor or a facility nurse. Resident #1's family member stated that at no time during the feeding was Resident #1 in any distress. During an interview on 6/16/26 at 5:05 PM, LVN A stated it was important to check for residuals prior to a G-tube feeding because it ensured the stomach was emptied properly and it prevented the risk for aspiration. LVN A stated she was aware nursing students participated in 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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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration of bolus feedings to residents. LVN A stated that from her understanding, nursing students were allowed to administer bolus feeding without the supervision of the clinical instructor or a nurse present once they were checked off on the bolus feeding skill (successfully demonstrated clinical competency in safely caring for and managing a feeding tube). LVN A stated she would hand off the feeding supplies to students so they could administer the bolus feedings. LVN A stated the clinical instructor would inform the facility nurses on which nursing students were checked off on the bolus feeding skill. During an interview on 6/16/26 at 6:35 PM, LVN B stated nursing students were allowed to administer bolus feeding alone when they were checked off by the clinical instructor. LVN B stated once the student was checked off, neither the clinical instructor nor a facility nurse had to be present during the administration of the feeding. LVN B stated she remembered nursing students approached her on several occasions to do the bolus feeding for Resident #1. LVN B stated she knew which nursing students were checked off because the instructor informed her. LVN B stated that when the nursing students were done administering the feeding, the student would inform her of the completed task. LVN B stated she would then go into the resident's room and check on the resident to ensure they tolerated the feeding well. LVN B stated she did not remember Resident #1 having issues with a bolus feeding provided by a nursing student. LVN B stated it was important to check for residuals prior to a G-tube feeding to prevent aspiration or abdominal discomfort. During an interview on 6/17/26 at 9:19am the Clinical Instructor stated that if the nursing students administered bolus feedings on their own, they were first checked off in a skills lab at school and then again at the nursing facility with a resident. She stated she was the one that checked off students on their skills. The Clinical Instructor stated that all students were aware of checking residuals before each bolus feeding. She stated that checking residuals was done to prevent aspiration. The Clinical Instructor stated that all the nursing students that were at the facility doing clinical work, had all been checked off to administer bolus feedings. The Clinical Instructor stated all the nursing students were competent to perform the skill without supervision. The Clinical Instructor stated she did not remember an incident where she arrived at the end of a bolus feeding for Resident #1. The Clinical Instructor stated that if a nursing student had made an error, they would follow the facility's policies to resolve the issue. The Clinical Instructor stated she could not provide student's personal information for interviews unless she had prior approval from [Nursing School]. During an interview on 6/18/26 at 11:22am the DON stated students were allowed to administer bolus feedings without supervision to residents once they were checked off by the Clinical Instructor. The DON stated he was not aware that there was an issue with a nursing student doing a bolus feeding on Resident #1. He stated that the Clinical Instructor did not allow the nursing students to perform the task alone unless they were checked off. The DON stated there was not an orientation on behalf of the facility when the students first started their clinicals at the facility, but they were provided with a tour. The DON stated that going forward, there would be a collaborative effort with the nursing school, and he would complete a facility competency check-off as well. The DON stated the facility did not have a policy regarding student nurses and performing tasks independently. During an interview on 6/18/26 at 11:52am the Administrator stated the facility did not have a protocol in place in relation to student nurses. She stated she would talk to the DON to get something in place. The Administrator stated that at the end of the day, the nursing students were just students. She stated if the nursing students were not licensed to do a procedure, then they should not have been doing things independently.There were no observations done of a student nurse providing a G-tube feeding because nursing students were on a school break. Record review of the facility's policies dated 06/18/26 revealed there was not a facility policy in place regarding student nurses providing care to residents.Record review of the facility's Resident Rights policy revised October 2009 revealed 3. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity. Record review of [Nursing school's] Affiliation Agreement with the facility, revised January 2025 revealed, Responsibilities of PartiesBoth parties will cooperate to (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide students with optimal clinical education opportunities to learn assigned tasks.Responsibilities of [Nursing School][Nursing School] will provide qualified instructors for clinical oversight and instruction.Instructors and students of [Nursing School] will comply with the policies of the Clinical Facility in carrying out clinical assignments and responsibilities.Responsibilities of the Clinical FacilityThe Clinical Facility may choose to assist in the clinical experience program by providing, through its supervisory personnel, regular evaluations of the students. 4.The Clinical Facility will appoint an appropriate member of the Facility to provide orientation to [Nursing School] faculty regarding Clinical Facility policies and rules. 6. The Clinical Facility will provide opportunities for practical and/or observational experience to supplement the instruction given by [Nursing School] but will retain full responsibility for patient care delivered at the facility.