STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676278	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pecan Bayou Nursing and Rehabilitation	2700 Memorial Park Dr Brownwood, TX 76801

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 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. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 in that: The facility's kitchen staff failed to practice proper hand hygiene during meal preparations. The facility failed to ensure kitchen staff handled ready to serve food with proper technique. The facility failed to ensure kitchen staff disposed of serving utensils when they became soiled. These failures placed residents at risk for food borne illness and cross-contamination. Findings included:During an observation on 08/25/2025 12:45 PM to 1:00 PM revealed [NAME] B used her gloved hand, that had touched plates and serving utensils and picked up rolls with the same gloved hand. [NAME] B left the food service line to grab a stack of plate warmers from another part of kitchen. [NAME] B changed her gloves but failed to wash her hands. [NAME] B dropped the tongs for the cooked chicken into the pan that contained chicken and continued to use the soiled tongs. [NAME] B continued to use her gloved hand, that touched the chicken, to pick up rolls. During an interview on 08/25/2025 at 1:15 PM the DDM stated her expectation was when staff changed gloves, they should have washed their hands. The DDM stated when a serving utensil was dropped into the food, the utensil should have been changed out for a new one. The DDM stated staff should have picked up rolls with tongs and not her gloved hand that was touching other food utensils. The DDM stated residents could have been affected by being exposed to cross contamination. The DDM stated the DM was responsible to ensure staff followed policies and procedures in the kitchen. The DDM stated staff nerves led to the failures that occurred. During an interview on 08/25/2025 at 1:45 PM [NAME] B stated she had only worked at the facility for 2 to 3 months and continued to learn as she went. [NAME] B stated she should have washed her hands when she changed her gloves and should have used tongs to pick up bread instead of her gloved hand that was touching everything else. [NAME] B stated residents could have been affected by cross contamination. [NAME] B stated what led to failure was being in a hurry and being nervous. During an interview on 08/25/2025 at 2:30 PM the DM stated her expectation was staff should have washed their hands when they changed gloves. The DM stated staff should have changed serving utensils when the utensils were dropped into food containers. The DM stated staff should have used the tongs to pick up rolls instead of using their gloved hand (that was being used to serve food). The DM stated she was responsible to ensure staff followed the policy and procedures. The DM stated residents could have gotten sick due to exposure to cross contamination. The DM stated what led to failure was staff was nervous. Record review of facility provided policy titled, Food: Preparation dated 2/2025 revealed: All staff will practice proper hand washing techniques and glove use. All utensils, food contact equipment, and food contact surfaces will be cleaned and sanitized after every use.Record review of facility provided policy titled, Food Handling during meal service without a date, revealed: The appropriate use of items such as gloves, tongs, deli paper, and spatulas is essential in minimizing the risk of food borne illness. Gloved hands are considered a food contact surface that can get contaminated or soiled. Disposable gloves are a single use item and should be discarded between and after each use. When serving food on the line, all food items should be handled by their designated utensil to minimize the risk of cross contamination.

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to implement its policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption for 3 of 8 (Resident #23, Resident #25 and Resident #62) residents reviewed for food and nutrition services. The facility failed to ensure that Resident #23 and Resident #25's personal refrigerator had a temperature log during the month of August 2025. The facility failed to ensure that Resident #62's personal refrigerator had temperature log completed from 08/19/2025 thru 08/26/2025. These failures could place residents at risk for foodborne illnesses. The findings were: During an observation on 08/26/2025 at 9:55 AM, revealed Resident #23' s personal refrigerator's temperature log was last dated 08/18/2025. Resident #23's refrigerator contained drinks. During an observation on 08/26/2025 at 10:37 AM, revealed Resident #62' s personal refrigerator did not have temperature log on the refrigerator. Resident #62's refrigerator contained drinks. During an observation on 08/27/2025 at 10:00 AM, revealed Resident #25' s personal refrigerator did not have temperature log on the refrigerator. Resident #25's refrigerator contained drinks. During an interview on 08/27/2025 at 10:17 AM the ADMN stated her expectation was refrigerators should have had thermometers in them and a temperature log on the refrigerator. The ADMN stated the department managers were assigned rooms to make daily rounds and during their daily rounds they were supposed to check and log the temperatures of the refrigerator. The ADMN stated residents could have received food that had spoiled. The ADMN stated what led to failure was miscommunication between staff. The ADMN stated she did not have a policy for refrigerator temperatures being checked and logged. During an interview on 08/27/2025 at 2:02 PM the ADON stated Resident #62 was one of the residents' rooms she was assigned to check daily. The ADON stated she was supposed to check the temperature of the refrigerator and log the temperature. The ADON stated she did not know why there was not a log on Resident #62's refrigerator. The ADON stated what led to failure was oversight on her part. The ADON stated the negative affect on residents could have been resident could have received food that was spoiled or items out of date. During an interview on 08/27/2025 at 2:25 PM Medical Records A stated she was assigned five rooms she was responsible to check daily and Resident #23 was one of her rooms. Medical Records A stated each refrigerator was supposed to have a thermometer and a log. Medical Records A stated residents could have had spoiled food in their refrigerator. Medical Records A stated what led to failure was oversight on her part.