

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675406	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Golden Years Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 318 Chambers St Marlin, TX 76661	

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. (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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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure menus met the nutritional needs of residents in accordance with established national guidelines, were prepared in advance and were followed for 1-of -1 reviewed for menus. 1. The facility failed to ensure current, accurate menus were provided and visible to residents for one dining area 2. The facility failed to ensure residents were offered individual menus for meal which is not a homelike environment. These deficient practices could place at risk of not getting food that they want or like. Findings included: Observation on 8-05-2025 at 11:15 am, revealed There were no menus posted in the dining room. The menu was written on the chalkboard right before residents were served lunch. There was only one menu in the facility on one of the halls. The menu located on information board from a previous month and did not include the current lunch items. The menu on the board was beef stew and baked ham was served, The menu on the board was in small print. Interview on 8/7/2025 at 9:30 AM, Resident #56 stated during, she did not know what meal she was going to have until the meal was brought to her room. She said she did not have a menu in her room. She stated she did not know where the menu was located. Resident #56 stated she would like to know if there were other options on the menu besides what she got. Resident did not know that she could get a menu. She stated that in the past she has received a menu in the past, but that has been several months ago. Interview on 8/7/2025 at 9:40 AM, Resident #7 stated during Sometimes the food is okay, but I would like to know what I am eating ahead of time. Resident #7 stated she was bed-bound and could not get out of the room to see what was on the menu. She stated she would like to know what she was having before they brought the food in case, she wanted something else. She expressed frustration about not knowing what was on the menu. Interview on 8/7/2025 at 9:50 PM, Resident #7 stated she did not know where the menu was in the building. She said she did not have a menu in her room and was not told what was on the menu. She said she did not know what she was going to get for her meal. Resident #7 stated she ate in the dining room and was unsure where the menu was in the facility. The resident stated she did not know what the substitute item was on the menu. Interview on 8/7/2025 at 9:50 AM, the DM stated during residents only got a menu if they asked for it. He said residents at the facility did not usually ask for a substitute meal because they liked the food being served. He said the menu was on the board towards the front of the facility. He said that was the only menu posted. He said they wrote down the menu on the chalkboard in the kitchen in the morning, so residents knew what they were having for lunch after breakfast is served. DM manager said he put the menu out for residents to see and it is the one that he gets from [NAME]. DM manager said besides the one menu that is posted he writes the menu on the chalk board in the dining room. Interview on 8/7/2025 at 11:10 AM, the ADM stated Residents should be able to have access to the menus so that they know what their meal is going to be The menu should be posted in more than one place in the facility, and it should be big enough for the residents to see. The menu is written on the chalkboard in the kitchen before the meal is served in the dining room. Record review of Menus and Adequate Nutrition Policy, revised on 7/16/2025, reflected Policy. Menus will be followed as posted. Notification of any deviations from the menu shall be made as soon as practicable. Substitution shall comprise of foods with comparable nutritive value. Menus shall be prepared at least two weeks in advance for timely approval and ordering of food. Menus will be posted in the kitchen and in areas accessible by residents at least one week in advance. Alternatives shall be immediately available if the primary menu or selections for a particular meal are not to a resident's liking. Review of the federal food code. Federal food safety regulations for nursing homes are primarily outlined in 42 CFR S 483.60, which addresses food and nutrition services. These regulations emphasize providing residents with a nourishing, palatable, and well-balanced diet that meets their individual nutritional needs and preferences. Key aspects include ensuring food safety, proper staffing, and adherence to dietary requirements.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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 in 1 of 1 kitchen reviewed for Food and Nutrition Services. 1. The facility failed to ensure that expired foods were discarded. 2. The facility failed to ensure the food processor was sanitized between each food item. 3. The facility failed to ensure food items were labeled and dated. 4. The facility failed to ensure that serving utensils and dishes were not stored dirty. These failures could place residents at risk for foodborne illness, causing the residents to get sick in 1 of 1 kitchen. Findings included: Observation on 8/05/2025 at 7:30 AM of the walk-in refrigerator reflected the following:- Tomatoes in a sealed bag were dated 7-22 with no discard date. - Strawberries in a container had no date and were moldy. - A cardboard box, dated 7-02-2025, contained green grapes were brown. - Sliced cheese in a Ziplock bag, dated 8-01-25, had no discard date. - Celery in a sealed bag, dated 8-02-25 had no discard date. - Asparagus in a Ziplock bag, dated 8-01-25, had no discard date. Observation on 8/05/2025 at 7:40 AM of the kitchen reflected the following:- Blue coffee cups on a dishwasher rack with other clean items had white debris on the cups. - Utensils in a dishwasher rack were mixed with clean and dirty utensils. - Serving utensils stored in a clear container had food debris in with the serving utensils. Observation on 8/05/2025 at 11:04 AM of the kitchen reflected the following:CK A Pureed the green beans, then rinsed the food processor in hot water without sanitizing the food processor. There were still pureed green beans inside the food processor when CK A pureed baked beans. CK A then rinsed the blender in hot water, but it was not sanitized before pureeing the bread. CK A then Pureed the cabbage without sanitizing the food processor. CK A rinsed the blender in hot water and did not sanitize the food processor before pureeing the ham. Observation on 8/06/2025 at 11:15 AM of the kitchen reflected the following:CK A pureed the chicken, then rinsed the food processor in hot water without sanitizing it for the next food item. CK A pureed the green beans, then rinsed the food processor in hot water without sanitizing it for the next food item. CK A pureed the potatoes. An interview on 8/07/2025 at 10:20 AM with CK B CK B stated when he put a food item in a container, he added the date on the container. CK B stated he checked daily for expired food items. If he saw an expired food item, he then threw it away. CK B stated any prepared food items past 3 days were thrown away. CK2 said there was no list they went by that told him how many days an item could be stored before it was thrown away. CK B stated prepared food was stored for three days before being discarded. CK B stated the kitchen was cleaned daily. CK B said there was a cleaning checklist they used. CK B said he was supposed to clean and sanitize the food processor in between food items. CK B said he forgot to do it this time. CK B said he was supposed to change his gloves when he did something else and came back to pureeing food. CK B said it had been a while since there was any training. CK B stated a resident could get sick if the equipment was not thoroughly cleaned and he did not change his gloves. An interview on 8/07/2025 at 10:29 AM with the DA revealed when the truck arrived, all staff are responsible to make sure that food items are dated. When a prepared item was placed in a Ziplock bag, it should have the date it was stored and an expiration date. If she noticed food going bad, she informed the DM and disposed of it. The DA mentioned everyone checked the walk-in cooler for expired items. The DA said staff did not put the expiration date on the packages. The DA stated prepared items should be discarded after three days because then the item is not good. The DA said the kitchen was cleaned daily at the end of each shift, including sweeping and mopping. DA said that residents could get sick if hand hygiene was not followed. An interview on 8/07/2025 at 10:20 AM with the DM revealed they went by newest item in the back and the oldest in the front. The DM said items were checked daily to see if there were any expired food. If there was expired food in the cooler it should be thrown away. The DM said food should be labeled with the name of the item, the date it was added, as well as the expiration date. The DM stated there was a list that had the shelf life of different foods. The kitchen was cleaned and sanitized daily. There were policies for sanitation, hand hygiene and food storage. The DM stated if equipment and utensils were not sanitized or cleaned, then it could be an infection control issue. An interview on 8/07/2025 at 10:20 AM with the ADM revealed when a food item was prepared and stored in a Ziplock bag, it should have the date it was put in the bag and the expiration date. The DM said when there was an out-of-date item, it should be thrown out. Looking for items should be checked weekly by staff. The kitchen should be cleaned and sanitized daily. There were policies in place for out-of-date food and the food should be discarded, and Kitchen equipment should be sanitized. The expectations are for staff to check for out-of-date food items and sanitized equipment. The ADM stated if</p>		