STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165798	A. Building B. Wing	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmar Village	8900 C Avenue NE Cedar Rapids, IA 52402

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on clinical record review, resident interviews, resident council minutes, call light device reports, staff interviews, and policy review the facility failed to provide sufficient nursing staff to ensure resident needs were met in a timely manner. During the survey residents reviewed for call lights reported waiting for 20 to 45 minutes for call lights to be answered and stated staff turned call lights off without completing cares. The facility reported a census of 44 residents. Findings include:A document titled Quality Concern Form dated 7/2/25 documented a resident waited 20 minutes for a second Certified Nurses Aide (CNA) to help with their transfer.A document titled Resident Council Meeting Minutes Template dated 7/14/25 documented 7 residents and 6 facility staff attended the meeting. The notes indicated call lights were ?still' not being answered in a timely manner and there was a new process for lights over 15 minutes. A resident reported to attendees that her call light was on for 30 minutes. Staff indicated they would access the call light report.A document titled Resident Council Meeting Minutes Template dated 8/11/25 included a call light follow up. The resident stated there was improvement but she still had call lights of 30 minutes. The new business section documented another resident reported aides came in, shut off the call light, and didn't come back to help for 20-30 minutes.A document titled Resident Council Meeting Minutes Template dated 9/8/25 revealed aides continued to shut off the call light without assisting them and the concerned resident felt the aides did it on purpose to get the light to go to management staff. Another resident continued to have lights of 30 minutes.The Administrator provided a report titled Device Activity Report dated from 9/24/25 12:00 AM to 10/1/25 11:59 PM which documented 33 instances of call lights between 16 minutes 4 seconds and 41 minutes 45 seconds on the second floor. During an interview on 9/29/25 with a resident who asked not to be identified, a family member reported they felt frustrated that the resident's call light was often out of reach when they came to visit. They stated it happed just the day before (9/28/25). They reported being present when staff entered the room for a call light, turned it off, and left without providing care. The aide stated they would be back in a minute and the family member reported a wait that time of 40 minutes. They stated wait times other days were 20 minutes to 45 minutes with the call light on, and up to 3 hours when the call light was turned off by an aide.During an interview on 9/29/25 at 12:11 PM another resident stated she attended resident council meetings where residents complained about call lights. She requested help looking into call lights because she waited about a half hour for a call light on 9/28/25 and it wasn't the first time. She knew it was that long because she checked her watch when she pulled the cord.During an interview with Staff A, Certified Nurses Aide (CNA) on 10/2/25 at 11:43 AM she acknowledged residents complained about the length of call lights and was aware there were family concerns as well. She reported a resident complained about being left on a bed pan and the call light not in reach.During an interview with the Director of Nursing on 10/2/25 at 12:18 PM she confirmed she expected call lights to be answered within 15 minutes and stated she knew there was a history of call light issues. She did not think there were current issues with turning call lights off or leaving residents on the bedpan too long, and thought the length of lights was getting better.The resident admission Agreement revised January 2017 documented Basic Care Services were included in the daily room rate. This (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included nursing and personal care services and other services as required by law. The section titled Resident Rights documented a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside of the facility. The facility must treat each resident with respect and dignity, and care for each resident in a manner and environment that promotes maintenance or enhancement of quality of life.

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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. Based on observations, staff interviews, facility documents review, and facility policy review, the facility failed to discard undated and expired food found in 2 of 3 kitchens. The facility food items not contaminated when scoops were left in containers during 2 of 2 main kitchen observations. The facility failed to log food temperatures, refrigerator/freezer temperatures, or dishwasher temperatures to ensure safe food storage, thorough cooking, and sanitation for 3 of 3 kitchen logs observed. The facility additionally failed to check the temperature of mechanically altered diets before serving to residents to ensure safe food holding temperatures during 1 of 2 lunch services observed. The facility reported a census of 44 residents.Findings include: 1. During the initial walkthrough of serving kitchen #2, located on the second floor of the facility, on 9/29/25 at 9:30 AM, observed a container of cut fruit covered with plastic cling undated and an opened bag of whipped cream undated in the refrigerator located next to the serving area. During an interview on 9/29/25 at 9:30 AM, the Dietary Manager stated all food items stored in the refrigerator must be labeled with an opened date or the date prepared. The Dietary Manager discarded the undated container of cut fruit and the undated bag of whipped cream found in a refrigerator in serving kitchen #2. During an initial walkthrough of the main kitchen on 9/29/25 at 9:40 AM, observed 4 plastic containers of coleslaw dated 9/25/25, inside a refrigerator near the serving area. Also, observed 2 large containers with lids, placed on a shelf, one contained white sugar, the other contained brown sugar both containers had a scoop remaining inside bin. During an interview on 9/29/25 at 9:40 AM, the Dietary Manager stated that the coleslaw, dated 9/25/25, found in the main kitchen refrigerator, should have been tossed out on 9/28/25. The Dietary Manager stated that kitchen staff know not to keep scoops in containers, and revealed that 3 staff had previously been written up on this. During a follow up walkthrough of the main kitchen on 9/30/25 at 10:45 AM, observed 4 plastic containers of coleslaw dated 9/2525 remained inside the refrigerator near the serving area. Also observed 2 large sugar containers on shelf in main kitchen continued to have scoops remaining inside bin.2. Review of the facility document titled, Food Temperature Record for Main Kitchen/Household, for the month of September 2025, lacked food temperature checks prior to service for 24 different meals. Review of the facility document titled, Dishwashing Record: High Temperature, for the main kitchen during the month of September 2025, to ensure dish sanitation, found to be completely blank except for an evening wash and rinse dishwasher temperature checked on 9/27/25 and 9/28/25. Review of the facility document titled, Dishwashing Record: High Temperature, for serving kitchen #2 during the month of September 2025, lacked dishwasher temperature checks to ensure sanitation for 17 out of 30 days.Review of the facility document titled, Dishwashing Record: High Temperature, for serving kitchen #1 during the month of September 2025, lacked dishwasher temperature checks to ensure sanitation for 8 out of 30 days.Review of the facility document titled, Equipment Temperature Record- Main Kitchen, Cooler and Freezer, for the month of September 2025, found to be completely blank, except for refrigerator and freezer temperatures checked on the dates 9/27/25 and 9/28/25. Review of the facility document titled Refrigerator and Freezer Temps- serving kitchen #2 during the month of September 2025, lacked an evening refrigerator temperature check, to ensure safe food storage, for 25 out of 30 evenings. Review of the facility document titled Refrigerator and Freezer Temps- serving kitchen #1 during the month of September 2025, lacked refrigerator temperature check, to ensure safe food storage, on both morning and evening shifts for 6 out of 30 days. During an interview on 10/2/25 at 11:08 AM, the Dietary Manager revealed the expectation of dietary staff to record all food temperatures prior to service, dishwasher wash and rinse temperatures to be recorded three times a day, and refrigerator/freezer temperatures to be recorded three times a day to ensure safe food storage, service, and dish sanitation.3. During an observation of noon meal service in serving kitchen #1 on 9/30/25 at 11:30 AM, the temperature of the food items kept in the steam table were checked by (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff F, Cook. Staff F pulled 2 metal pans from the warming storage unit, one contained minced and moist diet tuna casserole and one contained minced and moist diet broccoli. Staff F used scoops to plate 2 meals and served to 2 residents with minced and moist diets without checking the temperature of food to ensure safe food holding temperatures. During an interview on 9/30/25 at 12:45 PM, Staff F denied checking food temperatures for the minced and moist diets prior to serving to 2 residents and stated the food was steaming when removed from the warming storage unit. The facility was unable to provide policies for food storage, food temperatures, dishwasher temperatures, refrigerator/freezer temperatures, or kitchen sanitation.

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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 record review, resident, family, and staff interviews, and policy review the facility failed to ensure dignified care for 1 of 3 residents reviewed for dignity (Resident #31). The resident was left on a bed pan for over 3 hours with her call light out of reach. The facility reported a census of 44 residents.Findings include:Minimum Data Set for Resident #31 dated 7/9/25 revealed diagnoses of neurogenic bladder (disruption of nerve signals between the brain, spinal cord, and bladder that led to problems storing and emptying urine), non-Alzheimer's dementia, anxiety, and chronic pain. Section GG documented the resident was dependent on staff for hygiene and toileting hygiene, and transferring to the toilet was not attempted due to medical condition or safety.The Care Plan for Resident #31 dated 7/3/24 indicated the resident also had neurogenic bowel (loss of bowel control due to nerve damage) and a suprapubic catheter. As of 7/22/24, staff were directed to to treat the absence of bowel function per facility protocol or standing orders. As of 9/25/24, staff were directed to assess bowel and bladder function upon admission, quarterly, and per policy as needed. During an interview with the resident and her spouse on 9/29/25 at 1:05 PM, they reported the resident had been left on the bedpan for hours at least once on May 9 (2025) and again in July (7/13/25). When the resident's spouse visited May 9, the resident was also in the same clothes as the day before. During the incident in July her call light had not been placed close enough for her to call staff. The resident's spouse stated the call light was out of reach again yesterday (9/28/25) when they came for a visit. During this conversation Resident #31 stated she was afraid when she felt alone.A Progress Note titled General Note dated 7/13/25 at 5:15 PM documented the resident's POA (Power of Attorney) approached staff to report his wife had been on the bed pan since 2:00 PM when he left.A Progress Note titled General Note dated 7/13/25 at 6:32 PM revealed the Certified Nurses Aides (CNAs) did not give each other report at 2:00 PM and the CNA coming on duty did not know Resident #31 was put on the bed pan. The CNA was educated she was still responsible for checking her residents every 2 hours and when she came on duty. The nurse assessed and found the resident's skin was intact and without bruising. She did have a red ring around her buttock that was consistent with sitting on a bed pan.During an interview with Staff A, CNA on 10/2/25 at 11:43 AM she reported that Resident #31 complained 'every time' staff put her on the bed pan. She stated that after the last concern in July the facility started using a timer on her door.During an interview with the Director of Nursing on 10/2/25 at 12:18 PM when asked if she knew of bed pan concerns with the resident she stated she knew there was a history of that. She said there was a recent concern that some staff were using the timers on their phones instead of the one on the door and this was concerning to the resident's spouse.The facility admission Packet included a document titled Resident Rights revised August 2022. It indicated residents had a right to a dignified existence and self-determination. The facility must treat each resident with respect and dignity and care for residents in a manner and environment that promoted maintenance or enhancement of his or her quality of life.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, clinical record review, interviews, and policy review the facility failed to ensure a resident with limited Range of Motion (ROM) received appropriate treatment and services for 1 of 3 residents reviewed (Resident # 7). The facility reported a census of 44 residents.Findings include:The Minimum Data Set (MDS) for Resident #7 dated 9/3/25 documented diagnoses of non-Alzheimer's dementia, malnutrition, idiopathic peripheral autonomic neuropathy (nerve damage affecting involuntary bodily functions). The MDS indicated the resident was dependent on staff assistance for transfers, hygiene, and bed mobility and required the use of a wheelchair.The Care Plan for Resident #7 dated 12/3/24 documented an ADL (Activities of Daily Living) self-care performance deficit and limited physical mobility related to impaired mobility, generalized weakness, and impaired cognition, and end of life stage. The Care Plan intervention dated 9/16/25 directed staff to assess functional ability with bed mobility, transfers, walking, and locomotion at admission, quarterly, annually, with significant change and as needed. The care plan did not address active or passive range of motion (ROM).On 9/29/25 at 12:27 PM the resident was observed in a high back wheelchair with his feet on the pedals. The resident had modified cups for drinking and ate slowly but independently, 3 bites of chicken in 4 minutes. He appeared protective of his left side as evidenced by not moving his left shoulder, elbow, or wrist during the observation.The resident's Electronic Health Record (EHR) Task tab revealed the following for Active ROM: Bilateral upper and lower extremities seated (painful to L shoulder), 10 reps, 1-3x/wk or [Recumbent exercise machine] level 3 x10min, 1-3x/wk. Completion documentation indicated the resident had been offered ROM 1 time over the prior 30 days on 9/9/25. All other entries were marked not applicable.A document titled Maintenance Program dated 12/16/24 indicated the resident was an assist of 1 on the parallel bars and should stand for 1-3 minutes. It further documented staff should assist with upper and lower extremity bilateral active range of motion with a 3 pound dowel. On 10/1/25 the facility was asked for any additional range of motion documentation for the resident. At 3:53 PM the Administrator sent an email reporting the resident needed a new Maintenance Program assessment and that ROM for this resident was addressed with restorative therapy.A document titled Team Sheets provided 10/2/25, used by the Certified Nurses Aides (CNAs), included resident care needs. Resident #7's row did not include ROM support.During an interview with Staff B, Restorative Aide on 10/2/25 at 8:35 AM when asked about the resident's ROM program, she stated she should be doing range of motion exercises with him. She confirmed he was on her list but stated she had not gotten to Resident #7 lately. She stated therapy completed the Maintenance Program form, but she didn't know how often residents were reassessed. She did not think she had anything to do with that. When asked what she did if a resident refused, Staff B stated she just marked refused. She did not report that to anyone.During an interview with the Director of Nursing (DON) on 10/2/25 at 12:18 PM she stated the resident should be getting ROM from the Staff B. When asked how changes in condition were reported she indicated Staff B should be notifying therapy or the nurse. She thought they might start doing quarterly reviews as a new schedule for checking that. The DON stated it did not matter if a resident was on hospice, that all residents needing it should get ROM services.During the interview with the DON on 10/2/25 at 12:19 PM she was asked for policy or procedure related to ROM services. The facility did not provide one.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, employee file review, and facility policy review, the facility failed to ensure insulins were stored in a locked treatment cart for 1 of 2 medication storage carts observed, and failed to label insulin with date opened to ensure medicine was not expired for 1 of 1 insulin administrations observed (Resident #4). The facility additionally failed to ensure medications were safely administered to 1 of 4 residents (Resident #5) reviewed for medication administration, when medications were given to a family member to administer to a resident. The facility reported a census of 44 residents.Findings include: 1. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #4 had the diagnoses of Type 2 Diabetes Mellitus and received insulin injections daily.Review of the Care Plan, initiated [DATE], identified Resident #4 being at risk for alteration in blood glucose levels related to diagnosis of Diabetes Mellitus and instructed staff to give medications as ordered. Review of Resident #4's Order Summary revealed an active order for Novolog (Insulin Aspart) injection solution 100 units per milliliter (mL), with instructions to inject 10 units subcutaneously daily with meals for Diabetes Mellitus. The order was initiated on [DATE]. During an observation on [DATE] at 10:59 AM, Staff D, Registered Nurse (RN) prepared Resident #4's insulin pen at the first floor treatment cart. When queried if Resident #4's Novolog insulin pen had an opened or expiration date identified on label, Staff D stated the opened date was usually written on a sticker. Staff D revealed that the sticker for date identification had been left blank on Resident #4's Novolog insulin pen. Staff D denied having knowledge of when the insulin was opened or expired. Staff D, continued to Resident #4's room and administered the Novolog insulin injection. During an interview on 10/0125, at 9:30 AM, the Assistant Director of Nursing (ADON), revealed an expectation to label insulin pens with open and expiration dates to ensure medication was not expired. When queried about a resource for nursing staff to identify length of time insulin pens would expire after opening, the ADON stated that would be a good idea due to finding undated items. During an interview on [DATE], at 12:20 PM, the Director of Nursing (DON) revealed an expectation to label insulin pens with the open date to ensure insulin had not expired. The DON revealed the expectation of undated insulin pens to be discarded and replaced to ensure insulin administered was not expired. The facility policy, titled Medication Administration Policy, dated [DATE], directed, in part: Procedure Medication Administration Dates will be placed on medication container to monitor for expiration date if applicable. Expiration dates will be reviewed prior to administration of medication. 2. During an observation on [DATE] at 10:59 AM, Staff D, Registered Nurse (RN) prepared Resident #4's insulin pen at the first floor treatment cart, located in the dining room. The treatment cart, which contained insulins and medicated creams, remained unlocked as Staff D left the cart to enter Resident #4's room. During an interview on [DATE] at 10:20 AM, Staff D, RN, stated medication and treatment carts must be locked when staff leave the cart. During an interview on [DATE] at 12:20 PM, the DON revealed the expectation of treatment carts to be locked when not in use, to ensure safe storage of resident insulins and medicated treatments.3. Review of the MDS assessment dated [DATE] revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated moderate cognitive impairment. The list of diagnoses included osteoarthritis, anxiety disorder, depression, and other signs and symptoms with cognitive functions and awareness. The MDS indicated Resident #5 utilized antidepressant and antianxiety medications. Review of the Care Plan initiated on [DATE] revealed Resident #5 required someone to help read instructions, pamphlets, or other written material from the doctor or pharmacy and instructed staff to provide assistance when needed. The Care Plan identified Resident #5 had the potential for depressed mood related to anxiety, major depressive disorder, and statements regarding wanting to die, instructed staff to administer (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications as ordered.During an interview on [DATE] at 1:35 PM, Resident #5's family member stated that during a visit to facility on [DATE], Resident #5 was having increased pain which family believe caused Resident #5 to have agitation and anxiety. Family member stated she walked to the medication cart, located near 1st floor dining room, and requested antianxiety medication for Resident #5 from Staff E, Trained Medication Assistant (TMA). The family member stated that Staff E asked, Do you want me to give it to her, or do you want to? and gave the family member a Trazodone pill to administer to Resident #5. The family member reported walking down a long hallway from dining room, turning a corner, and walking down another long hallway to Resident #5's room with the Trazodone pill. The family member stated she administered the Trazodone to Resident #5 without staff present, and claimed Staff E remained at the medication cart. Review of the facility's grievance log, dated [DATE], revealed Resident #5's family member had reported a concern that occurred on [DATE], in which Staff E gave the family member Resident #5's Trazodone pill to administer to the resident. The facility listed action taken related to grievance was placing Staff E on administrative leave pending investigation on [DATE]. Review of Staff E's employee file revealed a form titled, Employee Corrective Action Notice, dated [DATE], for a written warning. The form revealed the description of issue, on [DATE], Staff E was observed preparing a medication (Trazodone) for a resident and handing it to a family member, resident's family member then proceeded to walk down the hallway with the medication, out of sight, while Staff E remained at medication cart near the nurse's station. The corrective action revealed that Staff E was unable to verify that the resident took the medication, which violated the six rights of medication administration. The corrective action form was signed by Staff E and Facility Administrator on Aug. 20, 2025. During an interview on [DATE] at 12:20 PM, the DON stated family members should not be given resident medication or administer medications to residents. The DON reported that Staff E had been suspended and educated when Resident #5's Trazodone was given to a family member. Review of the facility policy, titled Medication Administration Policy, dated [DATE], identified the policy statement was to ensure safe, effective, and timely drug therapy, to provide for an accurate and concise documentation system. The section A. Medication Administration directed, in part: 1. RN's, LPN's and TMA's will administer medications as ordered by the attending Physician/NP.2. The 8 rights of drug administration will be followed when administering all medication.Rights per the policy included the following: Right resident, Right drug, Right dose, Right dosage form (i.e. liquid, solid, crushed, etc.), Right route, Right time, Right reason, and Right documentation. 5. Medications prepared by authorized personnel are administered by that same staff member.

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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 - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review, and facility policy review, the facility failed to ensure a resident's with a diet order for Nothing Per Oral (NPO) was followed when the resident recieved a meal tray for 1 of 1 residents (Resident #4) on an NPO diet. The facility additionally failed to ensure residents on pureed diet received food listed on the menu or had Dietitian approved alternatives to menu items for 1 of 1 meals observed. The facility reported a census of 44 residents. Findings include: Findings include:1. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated moderate cognitive impairment. The list of diagnoses included non-Alzheimer's dementia, malnutrition, dysphagia (difficulty swallowing), and gastrostomy (g-tube) status. The MDS revealed Resident #4 had a feeding tube and received 51% or more of total calories through tube feeding. Review of the Care Plan revised 8/6/25 revealed Resident #4 required tube feeding due to dysphagia, was NPO, and may occasionally try to find snacks and eat by mouth. Interventions directed staff to see orders for tube feeding flushing and feeding instructions. Review of a General Note dated 5/27/25 at 3:46 PM documented Resident #4 was given scrambled eggs by mistake with no complications or respiratory issues and notification sent to Provider and received instruction to monitor Resident #4 for respiratory complications. Review of a General Note dated 8/5/25 a at 6:41 AM documented that nurse went into Resident #4's room at 4:30 AM for tube feeding and found a tray with 2 empty plates and utensils. The note revealed that when nurse inquired about the tray, Resident #4 confirmed received and ate a sandwich for supper. General Notes dated 8/5/25 at 7:27 AM and 10:25 AM revealed notification was sent to Provider, orders were received to continue to monitor Resident #4, and remind Certified Nursing Assistants (CNAs) that Resident #4 is NPO. Review of a Resident Occurrence Report dated 8/5/25 at 4:30 AM revealed Resident #4 was given food who should be NPO. An analysis as to cause of occurrence informed that there were two residents with same first name and an agency CNA had erroneously given Resident #4 a meal tray. During an interview on 10/1/25 at 4:25 PM, Staff G, Registered Nurse (RN) confirmed found room tray in Resident #4's room on 8/5/25, on top of the resident's refrigerator. Staff G stated she was shocked to find it because Resident #4 was supposed to be on an NPO diet and completed an incident report because of the resident's risk for aspiration. During an interview on 10/2/25 at 12:20 PM, the Director of Nursing (DON) revealed the expectation of all staff to be aware of and follow resident diets as ordered. The DON stated that Resident #4 was at risk for aspiration due to his dysphagia (difficulty swallowing).2. During an observation of noon meal service on 9/30/25 at 12:00 PM, Staff H, Cook, plated meals for 2 residents with pureed diets. One of the residents received a special order per her request of strawberry yogurt and a nutritional supplement drink and the other resident on a pureed diet received pureed chicken, corn, rice, and a cup of chocolate pudding for noon meal. Staff H stated that the facility purchased pre-made pureed food items which were heated and used to serve residents with a pureed diet. Staff H denied pureeing any food items for residents prior to the noon meal. Review of the facility's menu for 9/30/25 noon meal, revealed the following menu items were posted: chicken gumbo soup, tuna casserole, broccoli, and cheesecake.Alternative menu items included ginger chicken thigh and fried rice. During an interview on 10/2/25 at 10:43 AM, Dietitian revealed the expectation that dietary staff complete a substitution form for items used that are not listed on the approved menu to ensure that each resident receives adequate nutrition for each meal. During an interview on 10/2/25 at 11:08 AM, Dietary Manager confirmed that dietary staff were to complete a food substitution form when serving food that is not on the pre-approved menu for the Dietitian to sign off. The Dietary Manager was unable to locate a substitution form for pureed corn used instead of broccoli during the Sept. 30, 2025 noon meal. The facility lacked policy or procedures for NPO diets or menu item substitutions.