STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075394	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Long Ridge	710 Long Ridge Road Stamford, CT 06902

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, and staff interviews for 1 of 3 residents reviewed for choices (Resident #5), the facility failed to consistently provide a shower twice a week per the resident's preference. The findings include: Resident #5's diagnoses included quadriplegia and chronic pain. A care plan revised dated 5/16/2025 indicated Resident #5 had mobility impairment related to quadriplegia. Interventions included: transferring the resident to an adaptive wheelchair using a mechanical lift with the assistance of two staff members. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 was cognitively intact and did not exhibit behaviors of rejection of care. The MDS assessment further indicated Resident #5 was dependent for bathing and transferring. A physician's order reviewed on 7/8/2025 directed to shower/bath Resident #5 on Wednesday and Saturday. A Nurse Aide Care card directed that Resident # 5 receive a shower/bath on Wednesday and Saturday. The facility shower schedule for the second floor further identified Resident #5 was scheduled to receive a shower on Wednesdays and Saturdays. On 7/15/2025, an interview with Resident #5 identified she/he had not received a shower for the past three weeks. Resident #5 indicated she/he did not receive a shower on Wednesday 7/9/2025 because she/he had a doctor's appointment. The resident further indicated that when she/he requests a shower, staff either say they are too busy or did not answer. Resident #5 indicated she/he received a complete bed bath instead of a shower on his/her shower days. A review of the Nurse Aide flowsheets for bathing from 6/1/2025 through 7/17/2025 identified Resident # 5 last received a shower on 6/25/2025. For the dates 6/28, 7/5, 7/9, 7/12, 7/16/2025, when Resident #5 was scheduled to receive showers, the Nurse Aide flowsheet identified that the resident received a complete bed bath. A review of the nursing notes from 6/25/2025 through 7/17/2025 failed to identify any documentation of shower refusal. The nursing notes did indicate Resident #5 had doctor appointments on 7/2 and 7/16/2025. On 7/17/2025 at 12:40 PM, an interview with Nurse Aide (NA#2) identified she did not shower Resident #5 on 7/16/2025 because Resident #5 had a doctor's appointment in the morning. NA#2 indicated the resident returned around lunch time and did not request a shower. NA #2 further indicated that she did not offer a shower to the resident upon the resident's return. NA #2 indicated she showered Resident #5 on 7/9/2025 but could not recall who assisted her with the mechanical lift transfer to the shower chair. NA#2 indicated that her documentation of a complete bed bath for 7/9/2025 was made in error. NA#2 could not recall if she showered Resident #5 on 7/2/2025 or 6/28/2025. On 7/17/2025 at 1:06 PM, an interview with Licensed Practical Nurse (LPN #3) indicated Resident #5 does not refuse showers and she/he could not recall if the resident received a shower on 7/9/2025 or 7/2/2025. On 7/18/2025 at 9:33 AM, an interview with NA#3 indicated she could not recall showering Resident #5 on 7/5/2025 or 7/12/2025. NA#3 indicated she would have documented if she had provided a shower or if the resident had refused a shower. Based on NA#2's interview and the nurse aide flowsheet documentation, the resident received a shower on 6/25/2025 and then again on 7/9/2025 (two weeks later) with no evidence that Resident #5 received showers in between. On 7/21/2025 at 1:45 PM, an interview with the Director of Nursing Services (DNS) identified that residents are scheduled for two showers per week. Additionally, the DNS indicated if a resident is at a doctor's appointment and could not receive her/his shower, the resident should have an opportunity to have a shower later that day or another day, depending on the resident's preference. The facility policy for Activities of Daily Living (ADL) provided during the survey identified appropriate care and services would be provided for residents who are unable to carry out ADL independently with the consent of the residents and in accordance with the care plan.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation and staff interviews for 1 of 3 residents reviewed for abuse (Resident #73), the facility failed to ensure the resident was free from physical abuse. The findings include: 1. Resident #73's diagnoses included dementia, anxiety, and alcohol-induced psychotic disorder with hallucinations. The admission MDS assessment dated [DATE] identified Resident #73 had moderate cognitive impairment and had exhibited potential indicators of psychosis such as hallucinations and delusions. The MDS assessment further indicated Resident #73 had not exhibited behaviors directed towards others. A nursing note by Registered Nurse (RN #1) dated 4/1/2025 identified the charge nurse (LPN#2) reported Resident #73 had informed LPN#2 that she/he had been hit by his/her roommate (Resident #38). The nursing note further indicated the resident was assessed by RN#1, no injuries noted, and the appropriate staff were notified, including the police department. A social work note dated 4/1/2025 identified Resident #73 indicated Resident #38 had hit her/him on the right side of the chin. The note further indicated that the residents were separated, and responsible parties called. A psychotherapy note dated 4/17/2025 identified Resident #73 was alert and oriented times 3, felt comfortable and safe. The note further indicated the resident denied psychosis and depression. 2. Resident #38's diagnoses included stroke and dementia. The quarterly MDS assessment dated [DATE] identified Resident #38 was moderately cognitively impaired, had not exhibited potential indicators of psychosis, and exhibited no behaviors directed towards others. The MDS further identified Resident #38 required supervision or touching assistance for ambulation. A nursing note dated 4/1/2025 by RN#1 indicated RN#1 went to Resident #38's room to evaluate the resident and noted Resident #38 was sitting on the floor leaning against the closet at the foot of her/his roommate's bed. The nursing note indicated the provider Advanced Practice Registered Nurse (APRN #1) was notified, and new laboratory blood work were ordered. A social work note dated 4/1/2025 identified Resident #38 reported she/he had hit her/his roommate (Resident #73) in the face. The note indicated the residents were separated, appropriate staff were notified, the resident representative and the police department were also notified. An APRN note dated 4/2/2025 by APRN #1 identified Resident #38 had an episode of confusion, a fall, and physically assaulted her/his roommate on 4/1/2025. The APRN note further indicated Resident #38's laboratory blood work had come back positive for a Urinary Tract Infection (UTI) and Resident #38 had a history of confusion with urinary tract infections. A psychiatry note dated 4/2/2025 by APRN #2 identified Resident #38 was able to recall the incident with Resident #73 and voiced sorrow for her/his actions. The psychiatry notes further indicated Resident #38 was diagnosed with a urinary tract infection and was not a danger to self or others. A Facility Incident Report dated 4/1/2025 identified Resident #73 as alert and oriented to self, place, time, and situation, reported to LPN #2 that her/his roommate had punched her/him on the side of his/her face. The Facility Incident Report further indicated Resident #38 was alert and confused at the time, acknowledged punching her/his roommate but was unable to state the reason why. The Facility Incident Report also identified Resident #38 was placed on every 30-minute checks. On 7/15/2025 at 11:43 AM Resident #73 identified that a few months ago, she/he was punched on the chin by her/his roommate. Resident #73 indicated she/he believed Resident #38 punched her/him because she/he was ignoring Resident #38's confused conversations. Resident #73 indicated she/he notified the staff, and staff seemed supportive and denied being afraid. On 7/15/2025 at 1:29 PM Resident #38 identified she/he punched his/her roommate almost four months ago. Resident #38 indicated her/his roommate had gotten her/him frazzled but she/he felt bad about it. Resident #73 indicated that she/he was content with her/his current roommate. On 7/18/2025 at 12:03 PM, an interview with Social Worker #1 identified after the incident was reported to her by LPN#2, she interviewed Resident #38, who indicated to her that she/he did not know why she/he had hit his/her roommate but expressed remorse. On 7/18/2025 at 12:16 PM, an interview with LPN #2 indicated she found out about the incident because Resident #73 walked up to the nurses' station and informed her that she/he had been punched by her/his roommate. LPN#2 indicated Resident #38 was in the shared room, but LPN #2 could not recall what Resident #38 said when questioned about the incident. On 7/21/2025 at 12:39 PM, an interview with RN#1 indicated she could not recall the details about the incident but remembered calling the on-call provider and receiving orders for blood work since the resident was confused. On 7/21/2025 at 12:45 PM, an interview with APRN #2 indicated Resident #38 had not had any prior incidents of violence or aggression and she attributed her/his behavior and the incident with her/his

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policy review and staff interviews for 1 of 3 residents (Resident #131) reviewed for abuse, the facility failed to complete a thorough investigation of the cause of an unwitnessed fall with bruising per facility policy. The findings include:Resident #131's diagnoses included coronary artery disease, hypertensive heart disease with heart failure, and essential tremors.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #131 was cognitively intact and required a wheelchair for mobility. The resident also required 2 or more helpers with toileting hygiene, personal hygiene, and shower transfer. The Resident Care Plan (RCP) updated on 1/22/25 identified Resident #131 was on hospice and goals of care directed supportive and palliative in nature.A nurse's note dated 2/19/25 at 2:30 PM identified Resident #131 stated she/he had a fall when she/he lost his/her balance when Resident #131 attempted to get up from her/his wheelchair on 2/14/25. The resident also alleged two staff members picked Resident #131 up. A review of the Reportable Event (RE) form dated 2/19/25 identified Resident #131 had an unwitnessed fall on the evening of 2/14/25 with no injury noted, physician and family were notified. However, the facility investigation included one statement from a nurse who stated she/he did not work with Resident #131 on 2/14/25.The RCP was updated on 3/5/25 for falls. Interventions included: all staff with Resident #131 to reinforce safety awareness and to remind the resident to call for assistance with transfer of moving items from one area to the next.Interview on 7/18/25 at 11:42 AM with Nurse Aide (NA# 7) identified she/he could not remember if she worked on the evening of 2/14/25. NA # 7 also could not remember Resident #131. She/he further indicated she/he was not asked to provide a statement.Interview on 7/18/25 at 12:03 PM with NA #6 identified she worked on the evening of 2/14/25 and did not work on the same wing Resident #131 was on. She further identified she was not aware of an unwitnessed fall and did not assist Resident #131 up from the ground. NA # 7 indicated she was not asked to provide a statement for 2/14/25. Interview on 7/18/25 at 12:17 PM with NA #1 identified she worked the evening of 2/14/25 at which time Resident #131 was on her assignment and she provided care. She further identified Resident #131 did not have a fall on 2/14/25 and no other staff members helped Resident #131 up from the floor. She indicated she did not notice any bruise to Resident #131's hands and she was not asked to provide a statement. Interview on 7/18/25 at 1:03 PM with Licensed Practical Nurse (LPN) 1 identified she worked and provided care to Resident #131 on the evening of 2/14/25, no bruising was noted on Resident #131's hands. She also identified Resident # 131, was alert and orientated and would have told her if something happened. LPN # 1 further indicated she did not provide a statement the evening in questioned.Interview on 7/18/25 at 1:30 PM with the Assistant Director of Nurses (ADNS) identified she submitted the RE dated 2/19/25 for an unwitnessed fall for Resident #131. She also started to investigate and collect statements The. ADNS identified she only had one statement from a nurse who did not provide care to Resident #131. The DNS also indicated she thought she had left paperwork for staff to fill out statements, but she did not have them. The DNS indicated she had completed her investigation and concluded Resident #131 was forgetful. She further identified that she did not note any bruising to Resident #131's hands.On 7/21/25 at 1:55 PM ADNS provided 3 statements from staff members that worked on 2/14/25 and stated they were not aware of a fall. Interview on 7/21/25 at 1:57 PM with ADNS identified she found staff statements and obtained one from NA #6 and LPN #1 on 2/9/25.Review of the facility's Policy; Assessing Falls and Their Causes dated March 2018 directed to continue to collect and evaluate information until the cause of falling is identified or it's determined that the cause cannot be found.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation facility policy and interview for 1 of 2 sampled residents (Resident #128) reviewed for Hospitalization, the facility failed to provide a bed hold form to the resident/resident representative when resident was sent to the hospital and follow policy and procedures. The findings include:Resident #128's diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction (stroke) affecting the right dominant side, aphasia (trouble with speaking, understanding, reading, writing), and atrial fibrillation. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #128 was intact cognitively and required the assistance of 2 or more helpers with toileting hygiene, showering, and transfers. The nurse's note dated 7/7/25 at 2:00 PM identified Resident #128 was transferred to the hospital via ambulance and Resident #128's responsible party was notified.The nurse's note dated 7/15/25 at 7:06 PM identified Resident #128 returned to the facility from the hospital.Observation on 7/17/25 at 9:50 AM identified Resident #128 sitting up in bed in his/her room with television on. A request to review the facility Bed Hold form on 7/18/25 at 12:13 PM identified no signature on form for Resident # 128.Interview with the Assistant Director of Nursing Services (ADNS) on 7/18/25 at 12:15 PM identified when a resident is transferred to the hospital the family is notified. The ADNS also indicated she would mail out the bed hold form to family to sign or have resident sign if possible. She further indicated she did not have Resident #128 sign the form and did not send the form in the mail to Resident #128's family members.Review of facility's policy; Bed-Holds and Return directed prior to transfers and therapeutic leaves; residents or resident representatives will be informed in writing of the bed-hold and return policy.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical review, review of policy and interview for the only resident reviewed for dementia (Resident #4), the facility failed to ensure staff initiated a care plan for a resident with dementia. The findings include: Resident #4's diagnosis includes dementia. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated dementia would be addressed in the care plan. On 7/18/2025 at 1:14 PM an interview and record review with the Assistant Director of Nursing Services (ADNS) indicated Resident #4 had a diagnosis of dementia, the admission MDS assessment indicated the facility would proceed with care planning for dementia. However, she/he did not know why nursing had not initiated a dementia care plan and would add a dementia care plan at this time (177 days or 5 months, 26 days later). The facility Policy labeled Comprehensive Care Planning indicated in part, each resident's comprehensive person-centered care plan is developed within 7 days of the completion of the required MDS assessment and no more than 21 days after admission. The comprehensive person-centered care plan describes the services that are to be furnished. The facility policy labeled Dementia Care indicated the purpose of dementia care is to provide person-centered, dignified and evidence-based care to residents with dementia in accordance to regulatory requirements and best practices in long-term care. Individualized care planning is to develop and regularly update the person-centered care plan, including specific interventions for memory support, behavior management, safety, meaningful engagement and incorporate resident routines, communication styles and cultural preferences.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy and interviews for 1 of 3 residents reviewed for nutrition (Resident #61), the facility failed to ensure staff reported weight discrepancies. The findings include: Resident # 61's diagnosis includes end stage renal disease, type 2 diabetes mellitus, and morbid obesity. The hospital Inter-Agency Referral Report dated 7/4/2025 at 11:08 AM indicated a weight of 98.3kg (converted to pounds 98.3 x 2.2 = 216.26 lbs.). A physician's order dated 7/4/2025 directed to obtain a weight monthly on the first day of the month on the 7:30AM to 3:30 PM shift. A physician's order dated 7/4/2025 directed to obtain a weekly weight times 4 weeks on Fridays on the 7:30 AM to 3:30 PM shift. The Vitals Report for weights entry dated 7/4/2025 at 11:24 PM indicated Resident #61's weight was 200.2 pounds and on 7/5/2025 at 9:44 PM weight was 200.2 pounds. On 7/6/2025 at 9:23 PM Resident #61's was entered at 200.3 pounds. The Vitals Report for weights dated 7/7/ 2025 at 2:34 PM indicated Resident #61's weight was 226 pounds (a 25. 7-pound weight gain in 1 day). The nutritional assessment dated [DATE] at 2:59 PM indicated Resident #61 was at risk for malnutrition and noted the resident's weight was 200.3 pounds, usual body weight is in the 220's. The nutritional assessment further indicated Resident # 61's ideal body weight was in the 100's with a nutritional related diagnosis of obesity. The nutritional assessment further indicated Resident #61 had no loss or gain in weight. The Initial Nutrition Assessment note dated 7/7/2025 at 3:16 PM indicated in part Resident #61 was on a renal carbohydrate-controlled diet and a fluid restriction of 1000cc per day. Additionally, the dietician indicated would start the plan of care, do meal rounds, check weights and attend care plan meetings. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #61 was cognitively intact, weighed 200 pounds, had no weight loss or gain and was on a therapeutic diet. Resident #61's care plan dated 7/15/2025 (initiated on 7/7/2025) indicated in part Resident #61 had a nutrition/hydration plan related to end stage renal disease, diabetes mellitus and obesity. Interventions included in part to obtain a weekly weight and intervene if a significant weight change occurred. On 7/21/2025 at 1:10 PM an interview and record review with the charge nurse for Resident #61, (LPN #5) indicated the difference in the weights documented in the vital signs section from admission 7/4/2025 and 7/5/2025 was 202.2 lbs. On 7/6/2025 the resident's weight was 202.3 lbs. However, the weight LPN # 5 documented on 7/7/2025 at 2:34 PM indicated Resident #61's weight was 226 pounds. The Specialized Treatment Center communication book was reviewed, and the weights were noted to be from 200-204 lbs. (not indicating the unit of weight used). LPN #5 indicated the difference in the weights could have been how the resident was weighed depending on whether the resident was standing or in a wheelchair. LPN # 5 further indicated she/he did not notify anyone about the differences in weight but would consult the supervisor as to how to proceed next. On 7/21/2025 at 1:20 PM an interview and record review with the Director of Nursing Services (DNS) after reviewing the weights documented in Resident #61's medical record indicated s/he would have expected the staff to have obtained a reweight, when the weight was noted to be 25.7 pounds more than the previously obtained weights. She also indicated if acute care is needed to notify the physician and the dietician. Further record review with the DNS indicated no notes were found regarding the weight discrepancy or if the physician and dietician were notified. The DNS indicated a weight would be obtained now. After the surveyor inquiry, a progress note dated 7/21/2025 at 4:24 PM indicated Resident # 61's weight had been fluctuating from 222.6 pound to 231 pounds since admission. The resident's weight today was 228 pounds per Specialized Treatment Center communication book. The note further indicated on admission 7/4/2025 the pre and post specialized treatment weight was 229 and 226.6. The APRN was notified, and an order was obtained to monitor weight 3 times weekly for 2 weeks. On 7/22/2025 at 11:40 AM an interview and record review with the DNS identified the weights from Specialized Treatment Center must be in kilograms. After surveyor inquiry, the facility called the Specialized Treatment Center to verify that the center obtains weights in kilograms not pounds. Further interviews with the DNS identified staff did not report any discrepancies in weights (greater than 5%) to her/him or the physician or the dietician. On 7/22/2025 at 12:29 PM an interview with the Dietician (who did not have access to the medical record) indicated she/he was not aware of the weight gain noted in the vital signs weight section of Resident #61's medical record. The Dietician indicated staff did not notify her/him of any changes in the resident's weight and the weight documented in her/his assessment was the weight that was available at the time. The facility policy labeled Weighing and Monitoring the Resident notes in part a significant weight loss or gain should be reported to

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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. (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on tour of the kitchen, observations, review of facility policy and staff interviews, the facility failed to ensure that expired food items were discarded in a timely manner, dishwasher temperatures and sanitizing sink sanitizer concentrations were consistently recorded. The facility also failed to ensure the 3-bay sink was used appropriately, and clean dishes were stored in a sanitary manner. The findings included: a An observation of the walk-in refrigerator with [NAME] #1 at 11:20 AM identified an open can of whipped cream with dry white substance on the tip of the can. There were also some brown stains on the metal-colored area of the can. The expiration date on the whipped cream can indicated Best by 5/14/2024. [NAME] #1 identified a dietary aide who arrives at 11:30 AM is responsible for deep cleaning the walk-in refrigerator. [NAME] #1 further indicated the facility had no longer need for whipped cream from the cans and is now using non-dairy whipped cream. [NAME] #1 was unable to identify why the can had not been discarded. b. A review of the dish machine temperature logs with [NAME] #1 and [NAME] #2 on 7/16/2025 at 2:10 PM identified for June 2025 missing documentation on dish machine temperatures for breakfast for 6/25/2025 and for breakfast and lunch on 6/30/2025. Interview with [NAME] #1 at the time of the observation identified she/he was unable to identify why the temperatures were missing for 6/25/25 and 6/30/25. c. A tour of the kitchen on 7/15/2025 at 10:44 AM with [NAME] #1 identified the Director of Dietary was unavailable at this time. An observation of the 3-bay sink identified there were pots and pans in the wash sink filled with water. The rinse sink was empty with no dishes, and the sanitizer sink was filled with sanitizing solution but no dishes. A review of the July 2025 Pot Sink Sanitation Record identified the concentration of sanitizer solution had been checked on 7/15/2025 (the day of the observation) for breakfast at 8:00 AM. The log further identified that the sanitizing solution concentration had also been tested for lunch, but no time was written, and lunch service had not started. Additionally, the log indicated the concentration for the sanitizing solution had been tested for dinner at 6:30 PM despite the time of the observation being 10:44 AM. [NAME] #1 was unable to indicate why the log had been pre-filled for lunch or dinner. [NAME] #1 was also unable to indicate which dietary aide had signed the log. A review of the June 2025 Pot Sink Sanitation Record identified the concentration of the sanitizing solution had not been recorded for dinner time for 6/25, 6/26, 6/27, 6/28, 6/29, and 6/30/2025. [NAME] #1 indicated that the 3-bay sink is used daily and for every meal and operating without difficulty and not out of order. On 7/16/2025 at 1:55 PM, an interview with Dietary Aide #2 identified she had checked the concentration of the sanitizing solution of the 3-bay sink for breakfast and lunch on 7/15/2025 but indicated she did not know who had pre-filled the dinner time area. On 7/16/2025 at 2:10 PM, an interview with [NAME] #2 identified the 3-bay sink is used for dinner service daily and for 7/15/2025, Dietary Aide #3 would have been the one to have checked the sanitizing solution. On 7/16/2025 at 2:35 PM, an interview with Dietary Aide #3 identified he had filled in the log for the concentration of the sanitizing solution of the 3-bay sink on 7/15/2025. Although Dietary Aide #3 denied pre-filling the log on 7/15/2025, he did identify that the signature was his and that sometimes he comes early before his shift starts to double-check his work, which he indicated he had done on 7/15/2025. On 7/16/2025 at 3:00 PM, an interview with the Administrator identified he was not aware that Dietary Aide #3 comes in before his shift starts to double-check his work. The Administrator further indicated that some dietary aides have been assigned administrative work by the Dietary Director. The Administrator indicated that Dietary Aide #3 may have made a mistake due to her/his vision. d. On 7/16/2025 at 1:50 PM, the wash sink of the 3-bay sink was noted to have water above the sink's water line and was overflowing into the rinse sink. [NAME] grease-like areas were noted floating in the soap suds of the wash sink. There was no dietary aide monitoring the water level. Inside the rinse sink, there were six metal-colored pots and pans as well as serving utensils. Upon finding a dietary aide (Dietary Aide #2) in the dish room and returning to the 3-bay sink, the wash sink faucet had been turned off, but the water remained above the water line. Dietary Aide #2 indicated a different aide was responsible for the 3-bay sink that day. At 2:00 PM, an interview with [NAME] #1 identified the wash sink water should not be overflowing onto clean dishes in the rinse sink. [NAME] #1 indicated she/he would ensure the dishes in the rinse sink be rewashed to prevent contamination. e. On 7/16/2025 at 1:55 PM, a visit to the kitchen identified a large fan, with a moderate amount of lint blowing onto clean plates on the clean side of the dish machine and on trays that were on a cart. An interview with Dietary Aide #1, who was working in the dish room, identified the fan is on to prevent the dish machine from overheating and could not elaborate. An interview with Dietary Aide #4, who was also working in the dish room, identified the fan is used to prevent the dish machine from