STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335236	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robinson Terrace	28652 State Highway 23 Stamford, NY 12167

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice for three of three (3 of 3) medication carts and one of two (1 of 2) medication rooms reviewed. Specifically, (a.) Fiveˆ(5) bottles of eye drops had no open and or expiration dates; (b.)ˆFiveˆˆ(5) insulin pens had no open dates; (c.)ˆTwoˆ(2)ˆ vial of insulin andˆtwo (2) insulin pensˆhad no open and or expiration dates;ˆ (d.) One (1) insulin pen had two open dates;ˆ (e.) Two (2) inhalers had no open and or expiration dates; (f.) One (1) bottle ofˆTuberculin Purified Protein Derivativeˆ(a sterile mixture of antigens used in the Mantoux skin test to detect Mycobacterium tuberculosis infection) had no open and or expiration date; (g.) Narcoticˆbox #2 (two) only had one of two (1 of 2) locks in a locked position.ˆ This is evidenced by: The facility's Policy and Procedureˆtitled,ˆ Storage of Medications reviewedˆ1/2025, documented the facility shall store all drugs and biologicals in a safe, secure, and orderly manner.ˆThe nursing staff shallˆbe responsible forˆmaintainingˆmedication storageˆandˆpreparation areasˆin a clean, safe, and sanitary manner.ˆBefore and after opening, all medications shall expire on the date specified by the manufacturer on the product label, unless the manufacturer has specificallyˆindicatedˆaˆshortenedˆexpirationˆonce opened on the product label itself. The facility's Policy and Procedureˆtitled, Administering Medications reviewed 1/2025,ˆdocumentedˆtheˆexpiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container. During an observation onˆ02/02/2026ˆatˆ12:17 PM, the Courtyard Unit Medication Cartˆtwo (2) contained two (2) bottles ofˆGenTealˆTearsˆeye dropsˆwith no open and or expiration dates; one (1) bottle of Systane eye drops with no open and orˆexpiration date; and one (1) bottle of Refresh Tears eye drops with no open and or expiration dates.ˆThe cart alsoˆcontainedˆtwoˆ(2) Lantus insulin pens,ˆone (1)ˆAdmelogˆSolostar insulin pen,ˆone (1)ˆHumalogˆpenˆandˆaˆLantus Kwikˆ Pen,ˆwithˆno open dates.ˆOne (1) Novolog insulin pen,ˆOne (1) Lantus insulin vial,ˆwithˆnoˆopen and orˆexpirationˆdates.ˆOne (1) fluticasone inhaler andˆone (1) Ventolin haler bothˆhadˆno openˆorˆexpirationˆdates.ˆˆ During an observation onˆ02/02/2026ˆatˆ12:20 PM, the Courtyard Medication Room refrigeratorˆcontainedˆone (1) bottle ofˆTuberculin Purified Protein Derivativeˆwith no open and orˆexpirationˆdates.ˆˆ During an observation onˆ02/02/2026ˆatˆ12:20 PM, the Courtyard Medication Room Narcoticˆbox #2 (two),ˆtheˆinside lock was left open.ˆˆ During an observation on 02/02/2026 at 12:30ˆPM,ˆthe Courtyard Medication Cart #1 (one)ˆcontainedˆone (1) bottle ofˆGenTealˆtears eye drops with no open and orˆexpirationˆdate.ˆˆ During an observation onˆ02/02/2026ˆatˆ1:05 PM,ˆtheˆBathgate Unit Medication Cart #2ˆ(two) containedˆtwoˆ(2)ˆHumalog Kwik insulin pensˆwithˆnoˆopenˆorˆexpirationˆdates,ˆandˆone (1)ˆHumulin R Insulin vial with no resident name and no openˆorˆexpirationˆdates. There was also one (1) Insulin Aspartˆpen withˆtwo open dates of 01/09/2026 and 01/23/2026.ˆˆ During an interview onˆ02/02/2026ˆatˆ12:20ˆPM, Licensed Practical Nurse #2 statedˆthey were unaware of a (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shortenedˆexpirationˆdate after opening any medications.ˆˆThey check theˆexpirationˆdate on the bottle.ˆ During an interview onˆ02/02/2026ˆatˆ1:05 PM, Licensed Practical Nurse #4ˆwas unable toˆidentifyˆtheˆexpirationˆdate of an opened HumalogˆinsulinˆKwin pen.ˆ(The surveyor noted that theˆpenˆhad no open orˆexpirationˆdate.)ˆLicensed Practical Nurse #4ˆstatedˆthey administeredˆHumalogˆinsulin this morning without knowledge of the open orˆexpirationˆdate.ˆThey thinkˆinsulinˆexpires after 30 days ofˆopening, butˆthey wereˆnot sure.ˆ During an interview onˆ02/02/2026 at 12:25ˆPM,ˆAssistantˆDirector of Nursing #1ˆstatedˆthere was a grid of medications with shortenedˆexpirationˆdatesˆafter openingˆin each medication room.ˆTheyˆaccompaniedˆthe surveyor to the medication room on the Courtyard Unit andˆwereˆunable toˆlocateˆthe grid.ˆTheyˆstatedˆit must have been removed. During an interview onˆ2/11/2026ˆatˆ10:30 AM, Director of Nursing #1 statedˆthat Assistantˆ Director of Nursing #1 assumes the role of Nurse Educator.ˆTheˆNurseˆEducator completes nursing competencies on each Registered Nurse and Licensed Practical Nurse prior toˆthe nurseˆadministering medications without supervision.ˆThe nurse would beˆobservedˆfor competence, then signed off.ˆA checklist of competencies would be completed with one competency for medication administration. ˆ 10 New York Codes, Rules, and Regulations 415.18(d)ˆ

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interviews during a recertification and abbreviated survey, the facility did not ensure that alleged violations involving abuse, were reported immediately, but not later than two (2) hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to officials (including to the State Agency). Additionally, the facility did not ensure a report of the results of all investigations were submitted to the State Agency, within five (5) working days of the incident, in accordance with State lawˆfor one (1)ˆ(Resident #125)ˆofˆfour (4)ˆresidents reviewed for abuse. Specifically,ˆfor Resident #125ˆan allegation ofˆphysicalˆabuse reported byˆtheˆresidentˆon 2/05/2024ˆat 12:15ˆPMˆwas not reported toˆTheˆNew York State Department of Health untilˆ7:01 PMˆand the results of the investigation were notˆsubmittedˆuntil 2/13/2024.ˆ ˆ This isˆevidencedˆby:ˆˆ ˆ Facility policy titled,ˆAbuse-Prohibition Protocol, Types of Abuse, Response/Reporting,ˆlast revised 1/2025, documentedˆany alleged violations involving mistreatment,ˆneglectˆor abuse, including serious injuries of an unknown source must be reported to the Administrator/Designee, Director of Nursing/Designeeˆorˆdepartment directorˆimmediately. An immediate investigation must beˆmade,ˆand the findings of suchˆinvestigationˆmustˆbe reported to the:ˆˆ Administrator/Designee within 24 hours of the occurrence/discovery of such incident.ˆ To theˆNYSDOHˆ(NewˆYorkˆStateˆDepartmentˆofˆHealth)ˆvia the Electronic Incident Reporting form within 24 hours of occurrence/discovery.ˆˆ The facilityˆmust report any suspected resident abuseˆimmediately, and no later than (2) two hours after the allegation if the incident resulted in physicalˆinjury.ˆˆˆ All other reportable incidents are to be communicated to the New York State Department of Healthˆwithin 24 hours.ˆˆ The facilityˆis required toˆreport the results of an investigation into an alleged abuse incident to the relevant authorities, such as the state Department of Health, within five business days of the incident occurring;ˆessentially, theyˆmust provide a full report on their findings within thatˆtimeframe.ˆˆ ˆ Resident #125:ˆ ˆ Resident #125ˆwas admitted to the facility with diagnoses ofˆmetabolic encephalopathyˆ(a brain dysfunction caused by chemical imbalances in the body due to underlying metabolic disturbances), cerebralˆinfarctionˆ(blood supply to part of the brain is blocked or reduced),ˆhemiplegiaˆ(paralysis)ˆof right dominantˆside.ˆThe Minimum Data Set (an assessment tool) datedˆ1/13/2024, documented the resident couldˆusuallyˆbeˆunderstood, couldˆusuallyˆunderstand others, and hadˆmoderateˆcognitiveˆimpairment.ˆˆ ˆ The facility Investigation Summary dated 2/05/2024ˆdocumentedˆon 2/05/2024ˆat 11:35ˆAM, the resident reportedˆto aˆCertified Nurse Aideˆthat a Licensed Practical Nurse shoved them in the chest the prior evening.ˆˆ ˆ A Nursing Home Incident Submission Report documented the facilityˆsubmittedˆa report of theˆsuspectedˆphysicalˆabuseˆto The New York State Department of Health on 2/05/2024 atˆ7:01ˆPM.ˆˆˆ ˆ The New York State Department of Health Nursing Home Investigative Report Submission form documented the investigation report wasˆsubmittedˆon 02/13/2024.ˆ ˆ During an interview onˆ2/12/2026, Administrator #1 statedˆthatˆinˆsubsequentˆinterviews, Resident #125 reported the Nurse did notˆtouch them, and theˆwitnessˆconfirmed this information, so the allegation was unfounded.ˆˆThey further stated that they did not recall why reporting of this was not completed within the reporting time frames. ˆˆ 10 New York Codes, Rules, and Regulations 415.4(b)(2)ˆ

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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 observation, record review, and interviews conducted during the recertification survey, the facility did not develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for two (2) (Residents #s 4 and 14) of 23 residents reviewed for Care Plans. Specifically, (a) Resident #4 did not have a person-centered care plan for pain, although they were receiving scheduled pain medication and were being monitored for pain, and (b) for Resident #14, a comprehensive care plan for hospice was not developed or implemented when the resident was admitted to hospice care on 12/29/2025.^^ ^ This is evidenced by:^^ ^ The facility policy titled, Care Plans, Comprehensive Person-Centered, last reviewed on 1/2026, documented a comprehensive, person-centered care plan that included measurable^objectives^and timetables to meet the resident's physical, psychosocial, and functional needs was developed and implemented for each resident. Care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment.^^ ^ Resident #4^ ^ Resident #4 was admitted to the facility with diagnoses of Alzheimer's disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline.^It is the most^common form^of dementia), right thigh bone break, and type 2 (two) diabetes (a chronic condition that happens when a person has persistently high blood sugar levels). The Minimum Data Set (an assessment tool) dated 1/14/2026, documented the individual was^usually able^to understand and be understood by others, and had severe cognitive impairment.^^ ^ A physician order dated 12/29/2025, documented Acetaminophen Extra Strength Tablet 500 milligram, give 2 (two)^tablets^by mouth 2 (two) times a day for pain.^^ ^ Resident #4's Medication Administration Record for January 2026 documented pain assessment every shift (when awake), and documented score every shift.^^ ^ There was no documented evidence that a care plan for pain was developed, although the resident was receiving pain medication and being^monitored^for pain.^^ ^ During an interview on 2/13/2026 at 12:52 PM, Registered Nurse #2 stated^there should be a care plan for a resident who gets pain medications such as Tylenol (Acetaminophen) and was being^monitored^for pain.^^ During an interview on 2/13/2026 at 11:05 AM, Administrator #1 stated that each unit^manager^and each department head developed and updated the care plan. They^stated^there should be a pain care plan for a resident who was receiving pain medication and was being^monitored^for pain.^^ ^ Resident #14^^ ^ Resident #14 was admitted to the facility with diagnoses of metastasized cancer (a disease that has spread from its original site to other parts of the body), hypertension (high blood pressure,^a condition where the force of blood against the artery walls is consistently too high), and type 2 (two) diabetes. ^The Minimum Data Set, dated [DATE], documented the resident was^usually able^to understand and be understood by others, and had severe cognitive impairment.^^ A hospice skilled nursing assessment dated [DATE],^documented Resident #14 was admitted to hospice services on 12/29/2025.^^ ^ There was no documented evidence that a care plan was developed for hospice care that began on 12/29/2025.^^ ^ During an interview on 2/02/2026 at 11:53 AM, Licensed Practical Nurse #1^stated^there was no written communication between the contracted hospice group and the facility. The hospice nurse would visit the resident and then talk with them about the resident.^^ ^During an interview on 1/30/2026 at 10:14 AM, Administrator #1^stated^there should be a hospice care plan in place for Resident #14.^^ ^ ^ 10 New York Code of Rules and Regulations 415.11(c)(1)^^

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the record review and interview conducted during the survey, the facility did not ensure that Resident #123 was free of a significant medication error. Specifically, two (2) prescribed anti-seizure medications, carbamazepine and primidone, were omitted after the resident's readmission from the hospital on [DATE]. The medications resumed after the resident experienced a seizure on 11/21/2022. Resident #123 was admitted to the facility with diagnosis ofˆepilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures caused by sudden, abnormal electricalˆactivity in the brain); Post-polio syndrome (muscle and joint weakness and pain that gets worse over time), and other schizophrenia (a chronic, severe mental disorder characterized by a distorted interpretation of reality, including hallucinations, delusions, and disorganized thinking/behavior). The Minimum Data Set (an assessment tool) dated 10/30/2022, documented that the resident could usually understand and was understood by others withˆintact cognition.ˆ Comprehensive Care Plan revised 1/28/2022ˆdocumentedˆResidentˆ#123 had Seizureˆ Disorder related to diagnosis ofˆepilepsy.ˆInterventions included to give medications as ordered, and monitor/document for effectiveness and side effects.ˆˆ Physicianˆ Nursing progress noteˆdatedˆ11/07/2022ˆdocumented Resident #123 was ordered Carbamazepine and Primidone, both for seizures. Resident #123's Medication Administration Record for 11/2022 Primidone 250 milligram tabletˆwas not administered from 11/16/2022 through 11/21/2022;ˆcarbamazepine 200 milligramsˆandˆcarbamazepine 100 milligrams were not administered from 11/16/2022 through 11/20/2022.ˆ The hospital Discharge summary dated [DATE] documented to start medications upon discharge, including: Carbamazepineˆ200ˆmilligramˆtablet. Take 400ˆmilligramsˆby mouth three times a day.ˆTakeˆat 9 AM, 2 PM, 7 PM;ˆ Carbamazepineˆ100ˆmilligramˆchewable tablet. Take 100ˆmilligrams byˆmouth twice daily,ˆatˆ9 AM and 7 PM, in addition to 400ˆmilligrams, threeˆtimes aˆday,ˆso at 9 AM and 7 PM gets a total of 500ˆmilligrams.ˆ Primidone 250ˆmilligramˆtablet,ˆtake 1 tablet by mouth daily.ˆ During an interview on 2/11/2026 at 10:30 AM, Administrator #1 statedˆResident #123 was on anti-seizure medications prior to 11/11/2022. They further stated that onˆ11/11/2022, Resident #123 was sent to the hospital for shortness of breath, was admitted and returned to the facility on [DATE].ˆAdministrator #1ˆstatedˆRegistered Nurse #1 readmitted Resident #123. On 11/21/2022, Resident #123 had a seizure. They further stated a Registered Nurse reviewed the resident's chart and noted the resident's seizure medications had not been reinstated upon return from the hospital. Surveyor requested documentation of post-incident, all nursing staff education but was not provided. Record review and interview revealed the facility took the following corrective actions prior to the start of the survey: The nurse education post incident dated 11/21/2022 documentedˆthat duringˆaˆrecent readmission, medication reconciliation was completed with review and double-checking of medications. However, because the medication list spanned multipleˆpages, one page was unintentionally not entered. As a result, prescribed medications wereˆnotˆresumedˆupon readmission. Medical Doctor #2ˆprogressˆnote datedˆ11/25/2022,ˆdocumentedˆResident #123ˆwasˆadmitted from the hospital onˆ11/16/2022; the Medical Directorˆcompleted a readmission History and Physicalˆonˆ11/18/2022.ˆ It appears, however, thatˆResident #123'sˆanti-seizure medications, carbamazepine,ˆwere inadvertentlyˆomitted per the reconciled medication list. This was discovered onˆMonday, 11/21/2022, and the medications were restarted at that time.ˆ During an interview on 2/11/2026 at 10:30 AM, Administrator #1 stated a facility investigation was launched; the provider was notified and reinstated the resident's seizure medications.ˆRegistered Nurse #1 was re-educatedˆon the medication reconciliation process andˆverbalized competency in the admission process.ˆAdministrator #1 statedˆthat medication reconciliationˆeducation was provided toˆall nursing staff.ˆAll new admissions and readmissions within the past 30 days were audited forˆpossible medicationˆreconciliation, and no errors were (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted.ˆAdministrator #1 stated the incident was brought to Quality Improvement forˆreview.ˆ 10 New York Codes, Rules, and Regulations 415.4 (b)(1)(i)ˆ

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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. Based on observation, record review, and interviews conducted during the survey, the facility did not ensureˆthat resident menus were followedˆto meet the resident's' nutritional needsˆfor two (2) (Resident #'s 10 and 11)ˆof four (4) residents reviewed. Specifically, Resident #10ˆwasˆnot served an adequateˆportionˆof chicken on their meal tray, andˆResident #11, who had a care plan of fluid deficit, did not receive tomato juice as listed on their meal ticket for two (2) observed meals.ˆˆ ˆ This is evidenced by:ˆˆ ˆ The facility policy titled Dietary Portion Control, revisedˆ9/2025,ˆdocumentedˆthat all foods served would follow standardized recipes and prescribedˆportionˆsizes to ensure nutritional adequacy, regulatory compliance, cost control, and resident satisfaction.ˆThe procedure included:ˆ #1.) standardized recipes: all menu items were prepared using standardized recipesˆand recipes identified yield and exact portion size; #2.)ˆportion control methods: food scales were used for protein verificationˆ, and that free-pouring or estimated portions were not permitted; and #3.) tray line accuracy:ˆtray tickets were verified before plating, and the portion must match the daily production sheet.ˆˆ ˆ The facility policy titled Dietary Menu Planning Policy, revised on 1/2026, documented that menus were planned, reviewed, and approved by a Registered Dietitian to ensure nutritional adequacy, therapeutic accuracy, and resident satisfaction. Foodˆpreferencesˆwere obtained at admission and reviewed quarterly.ˆUnder Monitoring, it documented tray audits, verified menu compliance, and resident satisfaction was reviewed. ˆ Resident #10ˆ ˆ Resident #10 was admitted to the facility with diagnoses ofˆradiculopathy lumbosacral region (a condition caused by compression of nerve roots in the lower back, leading to symptoms such as pain, numbness, or weakness that radiates down the legs),ˆage-related physical debilityˆ(gradual decline in physical function and strength that occurs with aging), and type two (2) diabetes (a chronic condition that happens when a person has persistently high blood sugar levels).ˆThe Minimum Data Set (an assessment tool) datedˆ1/29/2026,ˆdocumented that the resident was cognitively intact,ˆwasˆunderstood, and could understand others.ˆˆ ˆ During an interview on 1/29/2026 at 9:28 AM, Resident #10 stated food was a big concern andˆwasˆoften discussedˆat the Resident Council Meetings. Theyˆstatedˆsandwichesˆwere served without much on them such as tuna or egg salad.ˆˆ During a meal observation on 2/02/2026 at 11:46 AM, Resident #10's meal tray was tested in the dining room, and a replacement tray wasˆrequested. The meal ticket read: chicken cacciatore with tomato,ˆpeppers,ˆandˆmushrooms, egg noodles, green beans, and mandarin oranges. There were no mushrooms or peppersˆobservedˆon the plate. Some of the tomatoes were slightly hard. The egg noodles were dry and stuck together when lifted with a fork and some egg noodles wereˆobservedˆto be brown/burnt. There was one (1) bite sized (1 inch) ˆpiece of chickenˆobservedˆon the plate.ˆ During an interview on 2/02/2026 at 12:06 PM, Certified Nurse Aide #2 was asked toˆobserveˆResident #10's test tray and asked if the meal should have included mushrooms,ˆpeppers, and a largerˆportionˆof chicken. Certified Nurse Aide #2 statedˆthat, according to the ticket,ˆtheyˆshould haveˆgotten mushrooms and peppers, but all they saw were tomatoes.ˆThey furtherˆstated that there should have been a largerˆportionˆof chicken.ˆˆ During an interview on 2/13/2026 at 9:04 AM, Certified Nurse Aide #3ˆstatedˆthat sometimes the residents complained about the way the food looked and that the vegetables were overcooked. Theyˆstatedˆthe residentsˆdid not always get the condiments that they should on their tray like butter or creamer. Theyˆstatedˆif a resident did not like the food served, they would offer themˆanother meal or an alternative such as a sandwich.ˆˆ During an interview on 2/13/2026 at 9:14 AM, Licensed Practical Nurse #4ˆ statedˆthe residents complained about the food. Theyˆstatedˆthere was a lot of inconsistency with the food. The residents would not receive the items that they should on theirˆtraysˆ, and they would have to constantly call the kitchen to get them.ˆˆ During an interview on 2/13/2026 at 10:14 AM, Food Director #1 ˆstatedˆthey attended the food committee meetings. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Theyˆstatedˆthey measured out three (3) to four (4) ounces of protein for a meal. This surveyor showed Food Director #1 pictures of Resident #10's test tray, and theyˆstatedˆmushrooms and peppers should have been included in the meal. They furtherˆstatedˆthe resident should have received a full piece of chicken thigh.ˆˆ ˆ Resident #11ˆˆ ˆ Resident #11 was admitted to the facility with diagnoses ofˆcongestive heart failureˆ(a weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs), chronic obstructive pulmonary diseaseˆ(a group of lung diseases that block airflow and make it difficult to breathe), andˆtype 2 (two) diabetes.ˆThe Minimum Data Setˆdatedˆ12/11/2025, documentedˆthe residentˆwasˆusually ableˆto understand others,ˆwas usuallyˆunderstoodˆbyˆothers, and was cognitively intact.ˆ ˆ Resident #11's Comprehensive Care Plan forˆ fluid deficitˆinitiatedˆ5/20/2025, documentedˆthe resident had actual/potential for fluid deficit related to chronic diarrhea and poor intake.ˆUnder interventions it was documented to ensure the resident had access to thin liquids of choice whenever possible.ˆˆ ˆ During an interview on 1/28/2026 at 12:39 PM, Resident #11ˆstatedˆthe food was terrible and they were often not served everything on their ticket. Theyˆstatedˆmost food did not have a taste to it. They have talked with dietary about their concerns and have discussed it at Resident Council Meetingsˆ ˆ During a lunch observation on 2/10/2026 at 11:52 AM,ˆResident #11's meal ticket wasˆobservedˆto sayˆtomato juice, however the resident was not served tomato juice.ˆˆ During a lunch observation onˆ2/12/2026 at 12:14 PM, Resident #11's meal ticket wasˆobservedˆto sayˆtomato juice and margarine, however the resident was not served tomato juice or margarine.ˆThe cup of cranberry juice provided wasˆobservedˆtoˆonlyˆbeˆhalf full.ˆˆ ˆ During an interview on 2/13/2026 at 11:05 AM, Administrator #1 stated food complaints waxed and waned. Theyˆstatedˆabout a year and a half ago, there were some issues with the food, but it had gotten significantly better over the past year. Communication was better now if the kitchenˆwasˆout of something, and it would be discussed at morning report and shared with the residents. 10 NewˆYorkˆCodes,ˆRules, andˆRegulationˆ415.14(c)(1-3)ˆˆ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335236	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robinson Terrace	28652 State Highway 23 Stamford, NY 12167

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, record review, and interviews conducted during the recertification survey^and an abbreviated complaint survey, the facility did not ensure residents were provided food and drink that was palatable, flavorful, and/or^at an appetizing temperature for^two^(2) of^four (4) meals reviewed. Specifically,^appetizing^and palatable food was not served^during a lunch^meal on 2/02/2026, and diluted^cranberry juice was served at a^lunch^meal on^2/10/2026.^Additionally,^six (6) residents (Residents #'s^10,^11,^36,^88, 96, 110)^interviewed^stated^the food did not taste good. This is^evidenced^by:^^ The facility policy titled, Dietary^Menu Planning Policy,^revised on 1/2026,^documented^menus were planned, reviewed, and approved by a Registered Dietitian to ensure nutritional adequacy, therapeutic accuracy, and resident satisfaction.^Under Monitoring, it documented tray audits, verified menu compliance, and^resident satisfaction was reviewed.^^ During an interview on 1/28/2026^at 12:39 PM, Resident^#11^stated^the food^was terrible^and they were often not served everything^on their ticket. They^stated^most food did not have a taste to it. They spoke with dietary about their concerns and discussed it at Resident Council Meetings.^^ During an interview on 1/28/2026 at 1:35 PM, Resident #36^stated^the food was not the best, and the vegetables were too soft. They further^stated^the turkey served at lunch did not taste appealing to them and that it did not taste like real turkey.^^ During an interview on 1/29/2026 at 11:36 AM, Resident #96^stated^the food was horrible. They^stated^potatoes were served rock hard and the vegetables could be flattened like paste with a fork. They often ordered food deliveries and takeout because they did not like the food. They further^stated^they rarely ate the breakfast or lunch offered at the facility.^^ During an observation on 1/29/2026 at 12:06 PM, Certified Nurse Aide #1 brought a meal tray to Resident #96's room. The resident told Certified Nurse Aide #1 that they did not want it and asked them to take it away without having looked at it.^ During an interview on 1/29/2026^at 1:21 PM, Resident #88^stated^the food was bad^and cold. They^stated^the potatoes were so hard that they could not chew them.^^ During an interview on 1/29/2026 at 1:40 PM,^Resident #110^stated^the food did not look good^and it did not taste good.^^ During an interview on^1/29/2026 at 9:28 AM, Resident #10 stated^food^was a big concern^and^was^often discussed^at the Resident Council Meetings. They^stated^there^were^complaints about the quality^and the presentation of the food. The vegetables were not prepared well and^either overcooked or undercooked.^They^stated^they had^received^black bananas, noodles with nothing on them,^and^meat that^was so tough it^could not^be cut through.^They^stated^the juice was watered down.^ During a^meal observation on^2/02/2026 at 11:46 PM,^Resident #10's meal tray was^tested in the dining room, and a replacement tray was^requested.^The meal ticket read:^chicken cacciatore with tomato, peppers, and mushrooms, egg noodles, green beans, and mandarin oranges.^There were no mushrooms or peppers^observed^on the plate.^Some of the tomatoes were slightly hard.^The egg noodles were^dry and^stuck together when lifted with a fork^and some egg noodles were^observed^to be^brown/burnt.^There was one (1) bite sized^piece of chicken^observed^on the plate.^ During an interview on 2/02/2026 at 12:06 PM, Certified Nurse Aide #2 was asked to^observe^Resident #10's test tray and asked if the meal should have included mushrooms, peppers, and a larger^portion^of chicken. Certified Nurse Aide #2 stated that, according to the ticket, they should have gotten mushrooms and peppers, but all they saw were tomatoes. They further^stated that there should have been a larger^portion^of chicken.^^ During an observation on 2/02/2026 at 12:08 PM, Resident #^10^was^observed^leaving the table. Their^replacement meal was untouched other than^for^the mandarin oranges.^^ During an interview on 2/10/2026 at 11:52 AM, Resident #11^stated^their cranberry juice was lighter than the resident's juice that was sitting across from them.^^ During an observation on 2/10/2026 at 11:52 AM, Resident #11's cranberry juice was^observed^to be lighter in color than the resident's cranberry juice that was sitting across from them in the dining room. The resident sitting next to Resident #11 was^observed^to have cranberry (continued on next page)

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	335236	A. Building B. Wing	02/13/2026

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	juice that was lighter in color than Resident #11s, almost clear.^^ Dining Committee meeting notes dated^11/10/2025, documented^new issues^consisted of vegetables being overcooked or undercooked. It was also documented that some pasta was^hard, and the cooking process was explained.^^ During an interview on 2/13/2026 at 9:04 PM, Certified Nurse Aide #3 stated^that sometimes the residents complained^about the way the food looked^and that the^vegetables were overcooked.^They^stated^the residents^did not always get the condiments^that they should on their trays^like butter or creamer.^They^stated^if^a^resident did not like the food served, they^would offer them^another meal^or an alternative such as a sandwich.^^ During an interview on 2/13/2026 at^9:14 AM, Licensed Practical Nurse #4^stated^the residents complained about the food. They^stated^there was a lot of^inconsistency^with the food.^The residents^would not receive the items that they should on their tray, and they^would have to constantly call the kitchen to^get them.^^ During an interview^on 2/13/2026 at 10:14 AM,^Food Director #1^stated^they attended^the food committee meetings.^They^stated^residents complained about overcooked pasta^and undercooked^vegetables, but they found that this complaint depended on^the residents'^diet^consistency. They had conversations with the staff about^different ways^to hold food to prevent mushiness with the vegetables and reviewed the policy and procedure^with their staff.^Food Director #1^stated^the Registered Dietitian was on the unit and^would receive^complaints made by the residents and would bring the complaints to them. If there were complaints, they were also brought to their attention at the morning meeting or by the unit managers.^This surveyor showed^Food Director #1 pictures of Resident #10's test tray, and^they^stated^mushrooms and peppers should have been included in the meal. They^further^stated^the brown/burnt-looking egg noodles were held in the oven instead of the steam table, and that should not have been done.^When questioned about the cranberry juice,^Food Director #1^stated^they had an issue with the juice machine and called the vendor, which was why the cranberry juice appeared watered down.^They^stated^the machine was fixed.^^^ ^ During an interview on 2/13/2026 at 11:05 AM, Administrator #1 stated^food complaints waxed and waned. They^stated^about a year and a half ago that there were some issues with the food, but^it had^gotten significantly better over the past^year.^Communication was better now if the kitchen^was^out of something, and it would be discussed at morning report and shared with the residents.^They^stated^they got a new vendor for chicken^when the residents complained about the chicken.^ ^ 10NYCRR 415.14(d)(1)(2)^^ ^