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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>335383  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>St Cabrini Nursing Home  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>115 Broadway<br>Dobbs Ferry, NY 10522 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations and interviews during the abbreviated survey (2674027) the facility did not ensure that care was taken to protect the privacy of personal information to safeguard the content of the medical records from the unauthorized users. Specifically, on 1/29/2026 a surveyor observed on multiple units (unit 3 North and 2 South) medication carts unlocked and unattended with no privacy screen applied. on the computer. 1) at 10: 42am and 10:46am the surveyor observed on 3 north medication carts left unlocked and with no privacy screens applied. 2) On unit 2 south at 11:00 am and 11:03 am the surveyor observed medication carts on the unit left unattended with no privacy screen on the computer. Review of a Resident Rights to Privacy Policy dated 8/2004 documented it is the policy of the facility to treat each resident with consideration, respect, and full recognition of their dignity and individuality, including privacy in treatment and in the care for their personal needs. During an observation on 1/29/2026 at 10:42 am observed the medication cart left in the hallway unattended with no privacy screen on the computer. At 10:45 am Unit Manager # 2 walked past the medication cart and noticed it was unlocked and locked the cart and locked the computer screen. Unit Manager # 2 walked away from the cart. During an interview on 1/29/2026 at 10:46 am with Licensed Practical Nurse # 5 stated they were not aware that they did not have the privacy screen on the computer. During an observation on 1/29/2026 at 10:46 am observed the medication cart left near the nurse's station on 3 North unattended, and no privacy screen on the computer. Licensed Practical Nurse # 4 observed with a resident in the dining area obtaining vitals and administering medication. Licensed Practical Nurse # 4 returned to the medication cart at the nurse's station. During an interview on 1/29/2026 at 10:48 am with Licensed Practical Nurse # 4 stated they should have applied the privacy screen when they walked away from the cart. During an observation on 1/29/2026 at 11:00 am on unit 2 South the surveyor observed a medication cart was in front of room [ROOM NUMBER] with the screen open to Resident #6 medication administration record. Licensed Practical Nurse # 3 was inside the resident's room during the observation. During an interview on 1/29/2026 at 11:01 am with Licensed Practical Nurse # 3 they stated they were busy and forgot to apply the privacy screen on the computer. Their usual practice is to put the privacy screen on when they are not close to the cart. Practical Nurse # 3 stated that they should have locked the cart and apply the privacy screen. Licensed Practical Nurse # 3 demonstrated that they know how to apply the privacy screen on the computer. During an observation on 1/29/2026 at 11:03 am on unit 2 South Licensed Practical Nurse #2 was on the right side of the nurse station with a resident obtaining vitals. Medication cart was located on the left side of the nurse's station had no privacy screen on the computer. During an interview on 1/29/2026 at 11:04 am with Licensed Practical Nurse # 2, they stated they did not have the privacy screen on the computer, but the medication cart should the privacy screen applied. 10 NYCRR 415.3(e)(1)</p> |  |  |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations and interviews during the abbreviated survey (2674027) the facility failed to assure that medications were secure and inaccessible to unauthorized staff and residents. Specifically, on 1/29/2026 surveyor observed on unit 3 North 10: 42am and 10:46 am medication carts on the unit left unlocked, unattended with no privacy screen on the computer. On unit 2 south at 11:00 am and 11:03 am observed medication carts on the unit left unlocked, unattended with no privacy screen on the computer. Review of the facility's Medication Storage policy dated 12/2020 documented medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication. During an observation on 1/29/2026 at 10:42 am observed the medication cart left in the hallway unlocked and unattended. At 10:45 am Unit Manager # 2 walked past the medication cart and noticed it was unlocked and locked the cart and locked the computer screen. Unit Manager # 2 walked away from the cart. During an interview on 1/29/2026 at 10:46 am with Licensed Practical Nurse # 5 stated they were not aware that they left it unlocked and acknowledged that it should have been locked. During an observation on 1/29/2026 at 10:46 am observed the medication cart left near the nurse's station on 3 North unlock, unattended. Licensed Practical Nurse # 4 observed with a resident in the dining area obtaining vitals and administering medication. Licensed Practical Nurse # 4 returned to the medication cart at the nurse's station. During an interview on 1/29/2026 at 10:48 am with Licensed Practical Nurse # 4 stated that they thought that the cart was locked because they normally do lock the cart. Licensed Practical Nurse # 4 acknowledged that they should have locked the cart when they walked away from the cart. During an observation on 1/29/2026 at 11:00 am on unit 2 South medication cart was in front of room [ROOM NUMBER] with the screen opened to Resident #6 medication administration record and cart unlocked. Licensed Practical Nurse # 3 was inside the room with the resident and returned to the medication cart at 11:01am. During an interview on 1/29/2026 at 11:01 am with Licensed Practical Nurse # 3 stated they were busy and forgot to lock the cart, but they typically do lock the cart when they are not near the cart. Licensed Practical Nurse # 3 acknowledged that they should have locked the cart. During an observation on 1/29/2026 at 11:03 am on unit 2 South Licensed Practical Nurse #2 was on the right side of the nurse station with a resident obtaining vitals. Medication cart was located on the left side of the nurse's station unlocked. During an interview on 1/29/2026 at 11:04 am with Licensed Practical Nurse # 2 stated they did not lock the medication cart, but the medication cart should have been locked. 10 NYCRR 415.18(e)(1-4)</p> |  |  |