STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225366	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hathaway Manor Extended Care	863 Hathaway Road New Bedford, MA 02740

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on records reviewed and interviews for one of three sampled residents (Resident #1), the facility failed to ensure they maintained complete and accurate medical record when nursing documentation in Resident #1's Electronic Medication Administration Record (MAR) and the Controlled Substance Register was found to be incomplete and did not accurately reflect what medications were or were not administered.Findings include:Review of the Facility's Policy titled, Administration Procedure for all Medications, dated 09/20/13, indicated the following:- Check the MAR for order;-after administration, return to cart, and document administration in the MAR.Review of the Facility's Policy titled, Clinical Documentation, revised 12/29/25, indicated the following:-the licensed nurse notes the time and date of all medications administered in the MAR;- the nurse who administers the medications must document it in the resident's record;-if a scheduled medication is withheld or not given as ordered, the nurse documents this and lists the reason for the resident not receiving the medication;Resident #1 was admitted to the facility in December 2023, diagnoses included Parkinson's disease, atherosclerotic heart disease, hypercholesterolemia, hypertension, dysphagia, rheumatic aortic insufficiency, malignant neoplasm of the breast and thyroid disorder.Review of Resident #1's Physician's Active Orders Report, for February 2026, indicated his/her orders included the following:- Amlodipine besylate (an antihypertensive medication), give 5 milligrams (mg) tablet by mouth daily at 9:00 A.M. - Aspirin (an anti-inflammatory medication), give 81 mg tablet by mouth daily at 9:00 A.M. - Carbidopa-Levodopa (anti-parkinsonism medication) give 25 mg -100 mg tablet by mouth three times a day.- Letrozole (aromatase inhibitor - used for breast cancer) give 2.5 mg tablet by mouth daily at 9:00 A.M. - Losartan Potassium (anti-hypertensive medication) 25 mg tablet give three tablets (75 mg) by mouth daily at 9:00 A.M. - Hyoscyamine Sulphate (anti-cholinergic medication used for excessive saliva) solution 0.125 mg/1 milliliter (ml) by mouth three times a day.- Miralax (laxative) 17 grams (gm) powder for solution, mix 17 gm with liquid by mouth daily at 8:00 A.M. - Senna 8.6 mg (used for constipation) give one tablet by mouth twice a day.- Colace (stool softener) 100 mg capsule give one capsule by mouth daily at 9:00 A.M.-Atropine Sulfate (anti-cholinergic medication used for excessive saliva) 1% solution give two drops sublingual (under tongue) before meals.- Lexapro (antidepressant medication) 10 mg give one tablet by mouth daily at 8:00 A.M. - Albuterol Sulfate (bronchodilator) 0.083% solution give one unit dose inhalation once daily at 9:00 A.M. - Morphine Sulfate (opioid analgesic) solution 20 mg/ml give 0.25 ml = 5 mg by mouth twice daily.Review of Resident #1's February 2026 MAR indicated that on 02/09/26, the administration times for the following medications were coded as (H), held due to the previous shift nurse not having documented administration: 7:30 A.M. medications:-Atropine Sulfate 1% solution;8:00 A.M. medications:-Hyoscyamine Sulphate solution 0.125 mg/1 milliliter (ml);-Miralax 17 grams powder for solution;-Lexapro 10 mg;-Morphine Sulfate solution 20 mg/ml;9:00 A.M. medications- Amlodipine besylate 5 mg;- Aspirin 81 mg;- Carbidopa-Levodopa 25 mg -100 mg;- Letrozole 2.5 mg;- Losartan Potassium 25 mg;- Senna 8.6 mg;- Colace 100 mg;- Albuterol Sulfate 0.083% solution;Review of the Controlled Substances Register for Resident #1 indicated that his/her Morphine Sulfate solution was signed off as being administered on 02/09/26 at 8:00 A.M. This was inconsistent with the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225366	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2026
NAME OF PROVIDER OR SUPPLIER Hathaway Manor Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE 863 Hathaway Road New Bedford, MA 02740	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation in the Electronic MAR.During an interview on 03/17/26 at 1:50 P.M., the Assistant Director of Nurses (ADON) said that on 02/09/26 she relieved Nurse #4 and took over the care of Nurse #4's residents at approximately 11:30 A.M. (which included Resident #1). The ADON said that she noticed that Resident #1's morning medications had not been signed off as being administered by Nurse #4 in the Electronic MAR.The ADON said that she asked Nurse #4 if she administered Resident #1's morning medications to him/her and said that Nurse #4 said she had administered his/her morning medications. The ADON also said that Nurse #4 said she had not signed off that she had administered Resident #1's medications in the Electronic MAR, but did not explain why she had not signed them off in the Electronic MAR.The ADON said when a nurse administers a medication to a resident, they are required to document it in Electronic MAR immediately after administration. The ADON said that on 2/09/26, Nurse #4 went home without signing off that she had administered Resident #1's morning medications in the Electronic MAR. During an interview on 3/17/26 at 2:50 P.M., Nurse #5 said on 02/09/26 she worked the 3:00 P.M. through 11:00 P.M. shift. Nurse #5 said that when she went to administer medications to her residents, the Electronic MAR was in RED for Resident #1's morning medications. Nurse #5 said that when the Electronic MAR is in RED, it means that medications were not signed off as being administered and the Electronic MAR will remain in RED until the medications are signed off as being given, held or not given.Nurse #5 said that in order for the Electronic MAR not to be in RED, there has to be documentation to indicate what the status is of the medications. Nurse #5 said that she documented in Resident #1's Electronic MAR that his/her morning medications were held (H) due to the previous nurse not having completed the documentation. Nurse #5 said that after she documented that reason in the Electronic MAR, it was no longer RED and she was able to document that she administered the medications that were due for all of the Residents on her assigned shift.During a telephone interview on 03/18/26 at 10:50 A.M., Nurse #4 said that she worked on 02/09/26 from 7:00 A.M. through 11:30 A.M., (only the first half of the day shift). Nurse #4 said that she administered Resident #1's morning medications but did not sign them off in the Electronic MAR. Nurse #4 said that it was facility policy to sign off medications in the Electronic MAR immediately after administering them but said that day, she was very busy and just administered her residents morning medications without signing them off in the Electronic MAR.Nurse #4 said that after she administered all of her residents' medications, she went to the nurse's station to document in the Electronic MAR that she had administered the scheduled morning medications to all of her residents and was informed that she had to go home. Nurse #4 said that she went home without signing off in the Electronic MAR that she had administered Resident #1's morning medications.During a telephone interview on 03/18/26 at 11:35 A.M., the Director of Nurses (DON) said that on 02/09/26, Nurse #4 went home without signing off in the Electronic MAR that she had administered Resident #1's morning medications. The DON said that it was her expectation that nurses sign off in the Electronic MAR that medications were administered immediately after administering medications to their residents. The DON said that Nurse #4 did not follow the facility's policy for medication administration.