

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/16/2026
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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on interviews and records reviewed, for one of three sampled residents (Resident #1) who was severely cognitively impaired, unable to make their needs known and was dependent on staff for bed mobility, the Facility failed to ensure Resident #1 was free from the use of physical restraints when, on 5/27/26 during the overnight shift, Certified Nurse Aide #1 observed and reported to Nurse #1, that Resident #1, who was in bed, had each corner of the bed sheet that was on top of him/her, tied to the straps emanating (originating) from the beds air mattress, that was beneath him/her. Resident #1 was unable to untie and remove the bed sheet, which was therefore restraining him/her from getting up, if desired. Findings include: Review of the Facility Policy titled Resident Abuse Prevention, most recently revised 10/17/22, indicated that it was the policy of the Facility to ensure an environment free of abuse, which included freedom from physical restraints not medically required to treat the resident's condition. Review of Resident #1's clinical record indicated he/she was admitted to the Facility during January 2024 and his/her diagnoses included Alzheimer's Disease. Review of Resident #1's most recent Minimum Data Set Assessment, dated 4/21/26, indicated his/her cognitive patterns were severely impaired and he/she was dependent on staff members when transferring between surfaces and for bed mobility. Resident #1's Care Plan related to alteration in ability to provide self-care, dated as initiated 4/29/26, indicated it included a goal that Resident #1 would maintain dignity, comfort and cleanliness. Additional interventions, dated as initiated 4/29/26, indicated that Resident #1 was fully dependent on staff for activities of daily living. Review of the report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 5/27/26, indicated that a staff member (later identified as Certified Nurse Aide #1) found Resident #1 in bed on 5/27/26 during the 11:00 P.M. to 7:00 A.M. shift, with his/her top sheet (at each corner) tied to the air mattress straps and reported this observation to a staff member (later identified to be Nurse #1.) Review of Certified Nurse Aide (CNA) #1's Statement, dated 5/27/26, indicated that at 3:30 A.M. on 5/27/26, she found Resident #1 in bed with his/her top sheet tied to the mattress strings at each corner of the bed and reported her observation to Nurse #1. Review of Nurse #1's Statement, dated 5/27/26, indicated that on 5/27/26 at [sometime] around 5:00 A.M. or 5:30 A.M., CNA #1 told her that Resident #1's top sheet was tied in knots to the straps of his/her air mattress and tucked in where they were not easily visible. The Surveyor was unable to interview CNA #1 or Nurse #1 as they did not respond to the Department of Public Health's letter or telephone requests for an interview. During a telephone interview on 6/25/26 at 3:10 P.M., CNA #2 said that she cared for Resident #1 during the 3:00 P.M. to 11:00 P.M. shift on 5/26/26. CNA #2 said that Resident #1 followed his/her typically routine and she changed him/her into pajamas before dinner and fed him/her dinner. CNA #2 said that she last saw Resident #1 in bed when she provided incontinence care to Resident #1 sometime after dinner. CNA #2 said that because Resident #1 required two care givers, CNA #3 assisted her. CNA #2 said that Resident #1's bed sheet was not tied to the air mattress when she provided care to him/her and said that Resident #1 was unable to tie it him/herself. During an interview on 6/16/26 at 1:45 P.M. the Director of Nurses said that on 5/27/26, Nurse #1 told the Unit Manager that Resident #1's top sheet had been tied to the straps of the air mattress beneath him/her during the previous 11:00 P.M. to 7:00 A.M. shift. 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
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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's Internal Investigation indicated that although staff members denied tying Resident #1's bed sheet to his/her air mattress straps, thereby restricting his/her movement, Resident #1 was totally dependent on staff for care and physically incapable of doing it him/herself. On 6/16/24 the Facility was found to be in past non-compliance with an effective date of 6/05/26 and provided the Surveyor with a plan of correction which addressed the concern area as evidenced by: A. On 5/27/26, skin and pain assessments were completed by the Unit Manager for Resident #1 without findings of injury related to the alleged incident. B. Resident #1 was also assessed and monitored for emotional or behavioral changes with none noted. Resident #1 will be provided with support as needed. C. On 5/27/26, the Administrator/Director of Nursing suspended CNAs #1 and #2 and Nurses #1 and #2 pending their investigation. D. Between 5/27/26 and 6/03/26, all Facility staff were trained on the Facility Patient Abuse Policy, prohibition on restraint use and Abuse reporting. E. On 6/04/26 the Facility initiated rounding on all units by Unit Managers observing for the absence of devices that could be considered a restraint. F. Results of the Internal Investigation and observations made during rounds will be reviewed during the June 2026 QAPI Meeting, and ongoing as needed. G. The Administrator/designee are responsible for overall compliance.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews and records reviewed, for one of three sampled residents (Resident #1) who had been observed by two staff members restrained in bed when the bed sheet that was on top of him/her was tied (secured) to his/her mattress at each corner, the Facility failed to ensure staff consistently implemented and followed the Facility Abuse Policy, when the staff members did not immediately report the allegations to their shift supervisor or the Administrator/Designee, as required. Findings include: Review of the Facility Policy titled Resident Abuse Prevention, most recently revised 10/17/22, indicated that it was the policy of the Facility for all individuals to identify and report immediately to their supervisor any allegation of abuse. The Policy indicated that unreasonable confinement or restraint is considered physical abuse. Review of Resident #1's clinical record indicated he/she was admitted to the Facility during January 2024 and his/her diagnoses included Alzheimer's Disease. Review of Resident #1's most recent Minimum Data Set Assessment, dated 4/21/26, indicated his/her cognitive patterns were severely impaired and he/she was dependent on staff members when transferring between surfaces and for bed mobility. Review of the report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 5/27/26, indicated that a staff member (later identified as Certified Nurse Aide #1) found Resident #1 in bed with the top sheet tied to the air mattress straps and reported this observation to a staff member (later identified as Nurse #1). Review of Certified Nurse Aide (CNA) #1's Statement, dated 5/27/26, indicated that at 3:30 A.M. on 5/27/26, she found Resident #1 in bed with the top sheet (that was over him/her) tied to the mattress strings at each corner of the bed and reported her observation to Nurse #1. Review of Nurse #1's Statement, dated 5/27/26, indicated that on 5/27/26 (sometime) around 5:00 A.M. or 5:30 A.M. [more than an hour after finding Resident #1 restrained by his/her bed sheet] CNA #1 told her that Resident #1's top sheet was tied in knots to the straps of his/her air mattress and tucked in where they were not easily visible. The Surveyor was unable to interview Nurse #1 or CNA #1 as they did not respond to the Department of Public Health's letter or telephone requests for an interview. During an interview on 6/16/26 at 1:45 P.M. the Director of Nurses said that on 5/27/26 at 11:00 A.M. [six hours after being made aware of the restraint], Nurse #1 told the Unit Manager that Resident #1's top sheet had been tied to the straps of the air mattress beneath him/her. The Director of Nursing said that on 5/27/26, during an interview, CNA #1 told her that she had also found Resident #1's bed sheet tied to the air mattress on a prior occasion and said that she had reported that observation to Nurse #2. During a telephone interview on 6/26/26 at 11:00 A.M. Nurse #2 said that [prior to the incident on 5/27/26] on 5/23/26, CNA #1 had told him that Resident #1's bed sheet was tied to his/her bed. Nurse #2 said that he checked Resident #1's bed and did not see that the bed sheet was tied. Nurse #2 said that he did not understand CNA #1's statement as an indication of abuse and thought she was sharing a concern about how the bed had been made. Nurse #2 said that he did not report CNA #1's statements at that time (5/23/26) to his/her supervisor. The DON said that Nurse #1 and Nurse #2 had not immediately informed her or the Administrator of the allegations made by CNA #1 on 5/23/26 and 5/27/26, in accordance with the Facility Policy. On 6/16/24 the Facility was found to be in past non-compliance with an effective date of 6/05/26 and provided the Surveyor with a plan of correction which addressed the concern as evidenced by: A. On 5/27/26, the Facility initiated an investigation of the allegation that Resident #1 had been restrained by a bed sheet. B. On 5/27/26, the Administrator/Director of Nursing suspended CNAs #1 and #2 and Nurses #1 and #2 pending investigation. C. Between 5/27/26 and 6/03/26, all Facility staff were trained on the Facility Patient Abuse Policy, prohibitions on restraint and Abuse reporting. D. Starting 5/28/26 and on-going, the Facility initiated review of the timeliness of reporting for all incident reports by the Director of Nurses/designee. E. Results of the Internal Investigation and incident report review will be reported during the June 2026 QAPI Meeting, and ongoing as needed. F. The Administrator/designee are responsible for overall compliance.		