

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 04/21/2026
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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure for one Resident (#11), out of a total sample of 26 residents, that each resident's drug regimen was free from unnecessary psychotropic medications to promote or maintain the Resident's highest practicable mental, physical, and psychosocial well-being. Specifically, the facility failed to ensure a physician's order for an as needed Trazodone (antidepressant) medication contained a duration of use and failed to ensure the prescriber reassessed the Resident's condition and documented a clinical rationale for the continued use of as needed Trazodone medication as required. Findings include: Review of the facility's policy titled Psychotropic Medications, last revised 9/18/24, indicated but was not limited to: Psychotropic medications can affect mood and behavior and include, but are not limited to, the following classes of medications: antidepressants. -As with all medications, psychotropics shall only be administered following an order by a physician or other person lawfully authorized to prescribe medications (the prescriber). -As needed (PRN) medications will require a 14-day order. -For psychotropic medications other than antipsychotics, for use beyond the initial PRN 14-day order, a prescriber must document the rationale for continuance, and the anticipated duration. Resident #11 was admitted to the facility in March 2023 with diagnoses including generalized anxiety disorder, Alzheimer's disease, and dementia with mood disturbance. Review of the Minimum Data Set (MDS) assessment, dated 3/27/26, indicated Resident #11 had a severe cognitive deficit as evidenced by staff interview and had received antidepressant medications. Review of Resident #11's current Physician's Orders indicated but was not limited to: Trazodone 50 milligram (mg) tablet, give one tablet daily by mouth daily as needed for agitation daily, order date 6/29/25. Further review of Resident #11's Physician's Orders failed to indicate the as needed Trazodone order had a stop date or a date to re-evaluate the continued use. Review of Resident #11's Nursing Notes, dated 1/12/26, indicated but was not limited to: - As needed Trazodone reviewed with the provider, continue current order for 30 days as Resident utilized it related to increased anxiety and agitation with effect. Further review of Resident #11's Nursing Notes failed to indicate the Trazodone had been reviewed with the prescribing Provider after 1/12/26. Review of the Physician's visit notes, dated 1/16/26 and 3/20/26, failed to indicate Resident #11's as needed Trazodone had been re-evaluated by the prescriber. Review of Resident #11's January Medication Administration Record (MAR) indicated as needed Trazodone was administered one time on 1/25/26. Review of Resident #11's February MAR indicated as needed Trazodone was administered four times on 2/8/26, 2/13/26, 2/16/26, and 2/22/26. Review of Resident #11's March MAR indicated as needed Trazodone was administered one time on 3/28/26. Review of Resident #11's April MAR, 4/1/26 through 4/21/26, indicated as needed Trazodone was administered five times on 4/5/26, 4/15/26, 4/16/26, 4/17/26, and 4/19/26. During an interview on 4/21/26 at 11:21 A.M., Nurse #2 said as needed psychotropic medications should have an order to re-evaluate the medication as indicated by the Physician. She said after the discussion with the provider there needed to be an order written with the provider's orders and a nurse's note to document the conversation with the Physician. During a telephonic interview on 4/21/26 at 12:54 P.M., the Physician said Resident #11 required as needed Trazodone to help with (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their behaviors related to their diagnoses. He said the facility protocol was for as needed psychotropic to be reviewed 14 days after initially being prescribed then every 30 days. He said something must have been missed. During an interview on 4/21/26 at 1:22 P.M., Unit Manager #1 said any psychotropic medications given on an as needed basis needed to be re-evaluated 14 days after the initial order then per the physician's order. She reviewed Resident #11's medical record and said the last time his/her as needed Trazodone order was re-evaluated by the physician was 1/12/26 and she did not see any further documented Trazodone reviews. During an interview on 4/21/26 at 1:38 P.M., Nurse #4 said an order would pop up in the Electronic Medical Record indicating a resident needed a medication reviewed with the provider. She said she would then speak to the provider and review the medication, then write an order to either continue the medication for a specified duration or discontinue, and document it in a nursing note and the provider would document the rationale in their note. During an interview on 4/21/26 at 2:57 P.M., the Assistant Director of Nursing said she reviewed Resident #11's chart. She said the last time Resident #11's as needed Trazodone was re-evaluated by the prescriber was on 1/12/26. She said an order was put in the Resident's medical record to re-evaluate the as needed dose of Trazodone in 30 days from 1/12/26, but that was not done as it should have been. Refer to F756		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to ensure a person-centered individualized comprehensive care plan was developed and implemented for two Residents (#90 and #80), out of a total sample of 26 residents. Specifically, the facility failed:1. For Resident #90, to develop a care plan for a cervical (upper neck) fracture; and2. For Resident #80, to develop a care plan for smoking. Findings include: Review of the facility's policy titled Care Planning, dated as last revised 2/15/25, indicated but was not limited to the following: -The facility will develop and implement a comprehensive person-centered care plan to include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. -The standardized care plans must be individualized for the resident by adding care needs/preferences, interventions, and resident specific strategies based on the assessment of a resident's needs, strengths, goals, life history, and preferences. 1. Resident #90 was admitted to the facility in March 2025 with diagnoses which included dementia, arthritis, failure to thrive, and history of falling. Review of the Minimum Data Set (MDS) Assessment, dated 3/27/26, indicated Resident #90 scored 0 out of 15 on the Brief Interview for Mental Status (BIMS) exam, indicating he/she had severe cognitive impairment. Review of the MDS assessment, dated 12/29/25, indicated he/she had sustained a fall with a major injury since the previous assessment. Review of the medical record including nursing progress notes, fall risk assessments, change in condition assessments, and hospital discharge documents indicated but were not limited to the following: -On 12/9/25 at 1:50 A.M, Resident #90 returned from the emergency room. The nursing progress note indicated he/she sustained a cervical fracture, and no surgical or invasive interventions would be performed due to his/her inability to tolerate the use of a cervical collar. -On 12/11/25 a Fall Risk Assessment indicated he/she had a fall on 12/7/25 and a fracture related to the fall. -On 12/29/25 a significant change MDS was completed due to a decline, weight loss, and recent cervical fracture. -The Hospital After Visit Summary, dated 12/8/25, indicated on page one, Resident #90 was seen in the emergency department because of a fall and had evidence of a possible fracture in their neck and they suspect it was an old finding. -The Hospital Transfer Summary, dated 12/8/25, indicated on page four and five, Resident #90 had a (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Computed Tomography Scan (CT Scan-imaging of the body using a combination of X-Rays and computer technology) of the cervical spine and head, the CT scan was compared to a previous CT scan from 3/20/25 and the impression/findings were an Acute non-displaced type II odontoid process fracture (sudden crack/incomplete break at the base of C2 Vertebrae, usually caused by falls and often managed with a hard collar for 6-12 weeks). Review of the Comprehensive Care Plan failed to indicate Resident #90 had a cervical fracture, if said cervical fracture was acute or chronic/old or if Resident #90 required any precautions/restrictions/interventions related to the cervical fracture. During an interview on 4/16/26 at 11:02 A.M, Nurse #3 said the fracture should have been documented whether acute or chronic in the medical record and it should have been care planned with orders, restrictions, and interventions and it was not. During an interview on 4/16/26 at 11:15 A.M., MDS Nurse #1 said she doesn't do the care plans only the MDS Assessments, but a care plan for the fracture should have been developed and it was not. During an interview on 4/16/26 at 11:25 A.M., the Director of Nurses (DON) said they should have developed a care plan for the cervical fracture and any recommendations/interventions needed to care for Resident #90. During an interview on 4/16/26 at 11:40 A.M., Consulting Staff #1 said a care plan should have been developed for the fracture. 2. Review of the facility's policy titled Resident Smoking Policy, dated as last revised 12/30/2025, indicated but was not limited to the following: -Residents who choose to smoke will be assessed to determine what level of supervision is required. -All cigarettes and smoking ignition materials, including matches and lighters, will be held and secured by facility staff in a designated location. -Determine the resident's independence and/or dependence with functional mobility outdoors, smoking ability, and the need for protective gear upon admission, quarterly, annually, with a significant change in resident's condition, and as needed as identified by Interdisciplinary Team. -Residents' care plan/Kardex will be kept updated, and interventions will be communicated to staff including assistance level needed, protective gear required, and any other resident specific interventions. Resident #80 was admitted to the facility in March 2025 with diagnoses including Alzheimer's disease and heart failure. Review of Resident #80's MDS assessment, dated 3/17/26, indicated he/she was cognitively intact as evidenced by a BIMS score of 15 out of 15. Additionally, the MDS indicated Resident #80 currently used tobacco. During an interview on 4/14/26 at 9:00 A.M., Resident #80 said he/she is an independent smoker. Resident #80 said he/she gets their smoking supplies from the nurses' station prior to going outside. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #80 said there are designated smoking times throughout the day. On 4/16/26 at 9:40 A.M. and 4/17/26 at 9:39 A.M., the surveyor observed Resident #80 return inside the facility after smoking and proceed to walk back towards his/her room with their rollator. On both occasions, the surveyor observed staff stop Resident #80 to remind him/her to turn in their smoking supplies at the nurses' station. Review of Smoking Assessments for Resident #80, dated 4/5/25, 9/5/25, 12/5/25, and 3/26/26, indicated the Resident did wish to smoke, and that he/she did not require supervision or a smoking apron. Review of the comprehensive care plans for Resident #80 failed to indicate a smoking care plan was developed or implemented. During an interview on 4/15/26 at 2:20 P.M., Nurse #1 said the process for smoking is that residents have designated times that they can go outside. Nurse #1 said the residents must stop at the nurses' station to retrieve their smoking supplies and to be let outside. Nurse #1 said all smoking supplies are kept at the nurses' station and no smoking supplies should be in resident rooms. Nurse #1 said Resident #80 does not always turn in their smoking supplies, and staff will have to remind Resident #80 to turn the smoking supplies in at the nurses' station. Nurse #1 said residents are assessed periodically to determine if they are safe to smoke independently. Nurse #1 said she is not sure if there is a place in the resident's chart other than the assessment to see a resident's smoking status. On 4/16/26 at 11:28 A.M., Certified Nursing Assistant (CNA) #1 said sometimes Resident #80 gets distracted after returning inside the facility from smoking and will need a reminder to turn in his/her smoking supplies. On 4/16/26 at 11:31 A.M., Nurse Manager #2 said the process for smoking is there are designated smoking times, and the residents who choose to smoke must go to the nurses' station to gather their supplies and be let outside. Nurse Manager #2 said when the residents return inside, they must stop at the nurses' station to return their smoking supplies. Nurse Manager #2 said Resident #80 does need reminders to turn in his/her smoking supplies at times. Nurse Manager #2 said she would expect a care plan to be developed and implemented for Resident #80 regarding his/her smoking status and that there should be an intervention specific to Resident #80 needing periodic reminders to turn in his/her smoking supplies. On 4/16/26 at 4:18 P.M., the DON said if a resident wishes to smoke, they are assessed to determine if they can smoke independently or needed supervision. The DON said she would expect a resident who is an independent smoker to have an individualized care plan in place. The DON said Resident #80 should have a care plan related to his/her smoking status.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility's Consultant Pharmacist failed to identify irregularities during the monthly Medication Regimen Review (MRR) related to the administration of an antidepressant medication for one Resident (#11), out of a total sample of 26 residents. Findings include: Review of the facility's policy titled Drug Regimen Review/Medication Regimen Review, last revised 10/6/22, indicated but was not limited to: In accordance with State and Federal Regulations, the Consultant Pharmacists will review each resident's clinical chart monthly, or more frequently depending on the resident's condition and the risks for adverse consequences related to current medications. This review of the clinical chart shall be comprehensive, and findings shall be documented on the Consultant Pharmacist Review/Signature sheet in the chart (or in the electronic medical record (EMR) if applicable). Apparent irregularities including, but not limited to, the use of any drug that meets criteria for an unnecessary drug will be reported in writing to the Director of Nursing, Medical Director, Attending Physician, and Administrator. Purpose: To ensure drug and medication regimen reviews are completed, received, and reviewed by appropriate personnel in a timely manner to promote positive patient outcomes and to prevent or minimize adverse consequences related to medication therapy, to the extent possible. A Consultant Pharmacist employs a systemic approach to medication management which includes consideration of: Duration-Consultant Pharmacist-identified irregularities may include, but not limited to one or more of the following: Unnecessary drugs, which may include: Excessive duration-Psychotropic drugs are given pursuant to a PRN (as needed) order for greater than 14 days, and the prescribed duration for the PRN order and/or rationale for this duration is not documented in the clinical record. Review of the facility's policy titled Psychotropic Medications, last revised 9/18/24, indicated but was not limited to: Psychotropic medications can affect mood and behavior and include, but are not limited to, the following classes of medications: antidepressants. As with all medications, psychotropics shall only be administered following an order by a physician or other person lawfully authorized to prescribe medications (the prescriber). As needed (PRN) medications will require a 14-day order. For psychotropic medications other than antipsychotics, for use beyond the initial PRN 14-day order, a prescriber must document the rationale for continuance, and the anticipated duration. Resident #11 was admitted to the facility in March 2023 with diagnoses including generalized anxiety disorder, Alzheimer's disease, and dementia with mood disturbance. Review of the Minimum Data Set (MDS) assessment, dated 3/27/26, indicated Resident #11 had a severe cognitive deficit as evidenced by staff interview and had received antidepressant medications. Review of Resident #11's current Physician's Orders indicated but was not limited to: Trazodone (antidepressant) 50 milligram (mg) tablet, give one tablet daily by mouth daily as needed for agitation daily, order date 6/29/25 Further review of Resident #11's Physician's Orders failed to indicate the as needed Trazodone order had a stop date or a date to re-evaluate the continued use. Review of Resident #11's Nursing Notes, dated 1/12/26, indicated but not limited to: As needed Trazodone reviewed with the provider, continue current order for 30 days as Resident utilized it related to increased anxiety and agitation with effect. Further review of Resident #11's Nursing Notes failed to indicate the Trazodone order had been reviewed with the prescribing Provider after 1/12/26. Review of the Physician visit notes, dated 1/16/26 and 3/20/26, provided to the surveyor failed to indicate Resident #11's as need Trazodone had been re-evaluated by the prescriber. Review of Resident #11's January Medication Administration Record (MAR) indicated as needed Trazodone was administered one time on 1/25/26. Review of Resident #11's February MAR indicated as needed Trazodone was administered four times on 2/8/26, 2/13/26, 2/16/26, and 2/22/26. Review of Resident #11's March MAR indicated as needed Trazodone was administered one time on 3/28/26. Review of Resident #11's April MAR, 4/1/26 to 4/21/26, indicated as needed Trazodone was administered five times on 4/5/26, 4/15/26, 4/16/26, 4/17/26, and 4/19/26. Review of the (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Consultant Pharmacist's Medication Review Assessments, dated 2/13/26, 3/12/26, and 4/12/26, indicated but was not limited to:-Type of Review: Monthly -Were any medication irregularities found or any medication recommendations made for provider review: No-Nursing/Provider Response: Not Applicable-Signed by the Consultant Pharmacists During an interview on 4/21/26 at 11:21 A.M., Nurse #2 said as needed psychotropic medications should have an order to re-evaluate the medication as indicated by the Physician. She said after the discussion with the provider there needed to be an order written with the providers orders and nurses note to document the conversation and Physician. During a telephonic interview on 4/21/26 at 12:07 P.M., the Consultant Pharmacist said as needed psychotropic medications needed to be re-evaluated by the provider periodically. He said he reviews every resident's chart monthly to check for irregularities. He said when he does a record review he checks for correct dose, duration, and appropriate use. He said if he notices an as needed psychotropic medication without a stop date, he will make a recommendation for the provider to continue to re-evaluate the medication and document the rationale to continue it. He said his process is if the provider does not address the recommendation, then he will make the recommendation again, and if it is not addressed for a third month then he would make a recommendation to continue to re-evaluate the medication and document the rationale to continue to use the medication periodically. He reviewed the MRRs for Resident #11 and said he has not made any recommendations for Resident #11 since October 2025 when had recommended for the provider to re-evaluate the as needed Trazodone and document why it should or should not be continued. He said he believes if he makes a recommendation twice in one year then he does not have to make them again for another year. During a telephonic interview on 4/21/26 at 12:54 P.M., the Physician said Resident #11 required as needed Trazodone to help with their behaviors. He said as needed psychotropic medications need to be reviewed every 14 days after initially being prescribed then to every 30 days. He said he relies on the Consultant Pharmacist's MRRs to catch any missed documentation or re-evaluations. He said the Pharmacist should have been his back-up in case something was missed. During an interview on 4/21/26 at 1:22 P.M, Unit Manager #1 said any psychotropic medications given on an as needed basis needed to be re-evaluated 14 days after the initial order then per the physician's order. She reviewed Resident #11's medical record and said the last time his/her as needed Trazodone order was re-evaluated by the physician was 1/12/26 and he/she had MRRs on 2/13/26, 3/12/26, and 4/12/26 with no recommendations. She said the Consultant Pharmacist would put recommendations in for an as needed psychotropic medication when he noticed they had not been re-evaluated and did not have an order to re-evaluate the medication. During an interview on 4/21/26 at 1:22 P.M., the Assistant Director of Nursing said the Consultant Pharmacist would make recommendations for psychotropic medications given on an as needed basis that had not been re-evaluated and documented with a rationale to continue it. She said this was not done.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a complete and accurate medical record was maintained for two Residents (#90 and #8), out of a total sample of 26 residents. Specifically, the facility failed to ensure:1. For Resident #90, a cervical fracture diagnosis was accurately documented; and2. For Resident #8, accurate COVID-19 test results were scanned into the medical record. Findings include:Review of the facility's policy titled Documentation-Clinical, dated as last revised 12/29/25, indicated but was not limited to the following:-Resident status, including change in condition, nursing or other services provided and resident response or progress will be documented as warranted.-Purpose is to ensure accuracy and completeness of clinical records. 1. Resident #90 was admitted to the facility in March 2025 with diagnoses which included dementia, arthritis, failure to thrive, and history of falling. Review of the Minimum Data Set (MDS) Assessment, dated 12/29/25, indicated Resident #90 had sustained a fall with a major injury since the previous assessment. Review of the Hospital After Visit Summary, dated 12/8/25, indicated on page one, Resident #90 was seen in the emergency department because of a fall and had evidence of a possible fracture in their neck and they suspect it was an old finding. Review of the Hospital Transfer Summary, dated 12/8/25, indicated on pages four and five, Resident #90 had a Computed Tomography Scan (CT Scan-imaging of the body using a combination of X-Rays and computer technology) of the cervical spine and head. The CT scan was compared to a previous CT scan from 3/20/25 and the impression/findings were an Acute non-displaced type II odontoid process fracture (sudden crack/incomplete break at the base of C2 Vertebrae, usually caused by falls and often managed with a hard collar for 6-12 weeks). Review of the physician progress notes, care plans, and diagnosis list from 12/8/25 through 4/16/26 failed to indicate Resident #90 had a cervical fracture or if said cervical fracture was acute or chronic/old. During an interview on 4/16/26 at 11:02 A.M, Nurse #3 said the hospital documents are not clear. She said the first page says the fracture might be old, but the CT scans clearly say the fracture is acute. She said there were not any additional notes or documents related to the fracture in the record. She said the fracture should be documented whether acute or chronic in the medical record and it was not. During an interview 4/16/26 at 11:15 A.M., MDS Nurse #1 said the MDS Assessment was coded as a fall with major injury because the CT scans indicated an acute fracture, but the conflicting information on the paperwork should have been clarified to ensure they had an accurate diagnosis to care for him/her. During an interview on 4/16/26 at 11:25 A.M., the Director of Nurses (DON) said they should have obtained clarifying documentation of the cervical fracture to ensure they had an accurate diagnosis to care for Resident #90 and that should have been documented in the medical record and it was not. During an interview on 4/16/26 at 11:35 A.M., the Administrator said the fracture diagnosis should have been clarified because the hospital paperwork had discrepancies whether the fracture was new or old and they would have to investigate it. During an interview on 4/16/26 at 11:40 A.M., Consulting Staff #1 said the diagnosis should have been clarified and at the very least documented in a progress note and it was not. She said there was nothing else related to the fracture scanned into the medical record. 2. Resident #8 was admitted to the facility in October 2025 with diagnoses which included Parkinson's disease, sepsis, and COVID-19. Review of the MDS Assessment, dated 4/1/26, indicated Resident #8 had been readmitted to the facility on [DATE]. Review of the medical record including physician and nursing progress notes, test results, and hospital discharge summary indicated but were not limited to the following:-On 3/16/26 Resident #8 was transferred to the hospital and returned on 3/26/26.-On 3/17/26 Resident #8 tested positive for COVID-19 and was on isolation precautions at the hospital.-A BINAXNOW COVID-19 Test scanned into his/her medical record, dated 3/20/26, indicated Resident #8 was asymptomatic and had a negative test result. During an interview on 4/16/26 at 11:02 A.M., (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.			
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #3 said she was unsure why that test result was scanned into the medical record because he/she was at the hospital on 3/20/26. During an interview on 4/16/26 at 3:34 P.M., the Assistant Director of Nursing (ADON) said that test dated 3/20/26 was not accurate, he/she was not in the building, so it was not possible the test was done. During an interview on 4/21/26 at 2:17 P.M., the Administrator said that test was not accurate, as Resident #8 was not in the building on 3/20/26.		