

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225782	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER The Commons Skilled Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Harvest Circle Lincoln, MA 01773	
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 - Some	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 three of three sampled residents (Resident #1, Resident #2, and Resident #3), the facility failed to ensure they maintained complete and accurate medical records, when their Certified Nurse Aide (CNA) flow sheets were left blank and the provision of care (e.g. bathing, dressing, grooming etc.) each resident required, was not documented as provided. Findings include: Review of the facility's policy titled, Charting and Documentation, with a revision date of 07/2017, indicated the following:-All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. 1. Resident #1 was admitted to the facility in November 2025, diagnoses included Type 2 Diabetes Mellitus, Hypertension and Urinary Tract Infection. Review of Resident #1's Certified Nurse Aide (CNA) flow sheets for the month of December 2025, indicated the following dates (day, evening, and night shifts) were left blank:-12/02/25-12/04/25 through 12/08/25-12/11/25-12/13/25 and 12/14/25. Resident #2 was admitted to the facility in December 2025, diagnoses included status post fall and right lower leg infection. Review of Resident #2's CNA flow sheets for the month of January 2026, indicated the following dates (day, evening, and night shifts) were left blank:-01/02/26 through 01/04/26-01/07/26 and 01/08/26-01/12/26 and 01/13/26. Resident #3 was admitted to the facility in December 2023, diagnoses included dementia and anxiety. Review of Resident #3's CNA flow sheets for the months of December 2025 and January 2026, indicated the following dates (day, evening, and night shifts) were left blank:-12/02/25 through 12/04/25-12/06/25 through 12/15/25-12/17/25 and 12/18/25-12/20/25 through 12/22/25-12/24/25 through 12/28/25-12/30/25 and 12/31/25-01/01/26-01/03/26-01/06/26 through 01/14/26. During an interview on 01/14/26 at 3:43 P.M., Certified Nurse Aide (CNA) #1 said they are supposed to document the care provided for each resident on the electronic CNA flow sheet once the care has been completed. CNA #1 said there was no [electronic] alert given to the CNA if the documentation was not completed. During a telephone interview on 01/16/26 at 11:53 A.M, the Director of Nurses (DON) said the Certified Nurse Aides (CNAs) were supposed to complete their flow sheets at the end of every shift. The DON said she was disappointed to see there were several missing days of CNA documentation for Resident #1, Resident #2 and Resident #3.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 225782
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