

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 03/25/2026
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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was dependent on staff to meet his/her care needs, the Facility failed to ensure he/she was provide quality care and treatment that met professional standards of practice, when on 01/23/26, after telling Certified Nurse Aide (CNA) #1 that he/she could not stand up any longer, CNA #1 helped lowered Resident #1 to the floor in his/her bathroom, however CNA #1 did not immediately inform nursing of the incident so he/she could be assessed for potential injury prior moving him/her, but instead waited to notify nursing after he picked Resident #1 up off the floor and transferred him/her back to bed. Findings include:Review of the facility's policy, titled Assessing Falls and Their Causes, dated 2001, indicated the following:-If a resident has just fallen or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities, and -If an assessment rules out significant injury, help the resident to a comfortable sitting, lying, or standing position, and then document the relevant details.Resident #1 was admitted to the facility in November 2025, diagnoses included non-[NAME] Lymphoma (type of blood cancer), left femur fracture, and a pelvic fracture.Review of Resident #1's Minimum Set Data Assessment, dated 11/12/25 indicated Resident #1 was dependent on staff to meet his/her care needs, and had intact cognition, evidenced by a Brief Interview for Mental Status (BIMS) score of 15/15.Review of an Incident Report, dated 01/23/26, indicated that CNA #1 lowered Resident #1 to the floor in his/her bathroom and Resident #1 sustained a right knee skin tear and a left calf hematoma.During an interview on 03/25/26 at 12:30 P.M., Resident #1 said that CNA #1 was helping him/her in the bathroom and that he/she stood up and faced the grab bar to hold on while CNA #1 provided care. Resident #1 said he/she told CNA #1 he/she needed to sit down because his/her knee was giving out and said he/she could not stand any longer. Resident #1 said CNA #1 told him/her to hold on for a minute, and because he/she could not stand any longer, CNA #1 had to lower him/her to the floor. Resident #1 said that he/she was crying because his/her right knee hurt. Resident #1 said he/she could not remember if CNA #1 got help or picked him/her up by himself. Resident #1 said once he/she was in bed, that the Nursing Supervisor and the Director of Nurses came in and asked him/her what happened.During a telephone interview on 03/25/26 at 11:06 A.M., CNA #1 said he was providing care for Resident #1 in the bathroom, he/she was standing facing the grab bar holding on, and that he had to lower him/her to the floor because he/she could not stand any longer. CNA #1 said he then got Resident #1 up by himself, put him/her in the wheelchair, and then transferred Resident #1 back to bed. CNA #1 said he did not notify a nurse until Resident #1 was back in bed, and he/she told him (CNA #1) that his/her right knee hurt. CNA #1 said he then told a nurse (exact name unknown) that he had lowered Resident #1 to the floor in the bathroom. CNA #1 said that if a resident has a fall, then a nurse should assess him/her before the resident is moved from the floor. CNA #1 said he had not considered this a fall because he had lowered Resident #1 to the floor.During a telephone interview on 03/26/26 at 208 P.M., Nurse #1 said she had not been notified by CNA #1 that he had lowered Resident #1 to the floor.During a telephone interview on 03/31/26 at 2:08 P.M., Nurse #2 said CNA #1 told her that Resident #1 got a skin tear on his/her knee during a transfer, so she went to Resident #1's room. Nurse #2 said she immediately told (continued on next page)</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>the Nursing Supervisor about the skin tear. Nurse #2 said that no one, including CNA #1, had informed her that Resident #1 had been lowered to the floor. During a telephone interview on 03/25/26 at 2:28 P.M., Nurse #3 said that CNA #1 had not told him that he lowered Resident #1 to the floor until after he picked him/her up, got him/her back to bed. Nurse #3 said a family member went to get the Nursing Supervisor. Nurse #3 said CNA #1 should have told him that he had lowered Resident #1 to the floor before he picked him/her up, so he/she could have been assessed, but he had not. During a telephone interview on 03/31/26 at 2:27 P.M., the (3:00 P.M. to 11:00 P.M.) Nursing Supervisor said she was called to Resident #1's unit by a family member who told her that Resident #1 had a fall. The Nursing Supervisor said CNA #1 told her that he was in the bathroom with Resident #1 and he tried to prevent him/her from falling by lowering him/her to the floor. The Nursing Supervisor said CNA #1 told her that he got Resident #1 up from the floor and transferred him/her back to bed. The Nursing Supervisor said that even though CNA #1 lowered Resident #1 to the floor, that this was considered a fall and Resident #1 should have been assessed for potential injury by a nurse before he/she (Resident #1) was moved up off of the floor. The Nursing Supervisor said CNA #1 should have pulled the emergency call light in the bathroom for help instead of getting Resident #1 up from the floor. During an in-person interview on 03/25/26 at 3:28 P.M. and a follow-up telephone interview on 03/31/26 at 3:49 P.M., the Director of Nurses (DON) said that based on her investigation, CNA #1 lowered Resident #1 to the floor in his/her bathroom, picked him/her up from the floor, and then put him/her back to bed without notifying a nurse until later. The DON said if a resident is lowered to the floor, it is still considered a fall, and a nurse must assess the resident for potential injury before he/she is moved. The DON said CNA #1 should have notified a nurse before he moved Resident #1 up off the floor.</p>		