STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225782	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Commons Skilled Nursing & Rehabilitation	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, record review and interview the facility failed to report an injury of unknown origin immediately, but not later than 2 hours after the injury was discovered, to the state agency, for one Resident (#51) out of a total sample of 17 residents. Findings include:Review of the facility policy titled Abuse, Neglect and Exploitation Prohibition and Prevention Program, dated August 2023 indicated that an injury of origin is an injury that is not observed by anyone, and cannot be explained by the resident. This type of injury is reported and investigated as potential abuse. Further review indicated that the facility must report injuries of unknown origin to the state agency within two hours. Resident #51 was admitted to the facility in November 2025 with diagnoses including dementia, and fracture of the left leg. Review of the medical record failed to indicate a completed Minimum Data set assessment.On 11/25/2025 at 8:15 A.M., the surveyor observed Resident #51's left hand to be swollen and bruised covering an area of approximately three inches in diameter. During an interview on 11/25/2025 at 8:15 A.M., Resident #51 said that the area hurts and that he/she did not know how it happened. Resident #51 also said that the area was not there yesterday. During an interview on 11/25/2025 at 8:17 A.M., Nurse #1 said that she noticed the area earlier this morning and gave the Resident Tylenol for pain. Nurse #1 said that she didn't work yesterday but did work on Sunday and the hand was not bruised or swollen on Sunday. During an interview on 11/25/25 at 1:16 P.M., the Director of Nursing said that she had found out about the bruise at 12:30 P.M., and had not started an investigation as to how the injury occurred and had not reported to the state agency. The Director of Nursing said that she didn't have to report the injury to the state agency right away and had 24 hours to do so because she didn't think that the injury was a result of abuse but was not able to determine the etiology of the injury. During an interview on 11/25/25 at 1:16 P.M., Physician #1 said that she was unable to determine how the injury occurred. The physician said that Resident #51 could have banged the area against something but was unable to determine the etiology.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, record review and interview the facility failed to immediately investigate an injury of unknown origin for one Resident (#51) out of a total sample of 17 residents. Findings include: Review of the facility policy titled Abuse, Neglect and Exploitation Prohibition and Prevention Program, dated August 2023 indicated that an injury of origin is an injury that is not observed by anyone, and cannot be explained by the resident. This type of injury is reported and investigated as potential abuse. Further review indicated that the facility must start an investigation into the etiology of the injury immediately. Resident #51 was admitted to the facility in November 2025 with diagnoses including dementia, and fracture of the left leg. Review of the medical record failed to indicate a completed Minimum Data set assessment.On 11/25/2025 at 8:15 A.M., the surveyor observed Resident #51's left hand to be swollen and bruised covering an area of approximately three inches in diameter. During an interview on 11/25/2025 at 8:15 A.M., Resident #51 said that the area hurts and that he/she did not know how it happened. Resident #51 also said that the area was not there yesterday. Review of the progress notes failed to mention the injury on Resident #51's left hand. During an interview on 11/25/2025 at 8:17 A.M., Nurse #1 said that she noticed the area earlier this morning. Nurse #1 said that she didn't work yesterday but did work on Sunday and said the hand was not bruised or swollen on Sunday. During an interview on 11/25/25 at 1:16 P.M., the Director of Nursing said that she didn't find out about the bruise until 12:30 P.M., and had not started an investigation as to how the injury occurred. During an interview on 11/25/25 at 1:16 P.M., Physician #1 said that she was unable to determine how the injury occurred. The physician said that Resident #51 could have banged the area against something but was unable to determine the etiology.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility to ensure that services provided met professional standards for one Resident (#39), out of 17 total sampled residents. Specifically, for Resident #39, the facility failed to complete a baseline AIMS (Abnormal Involuntary Movement Scale) assessment upon admission when prescribed an antipsychotic medication. Findings include: Resident #39 was admitted to the facility in November 2025 with diagnoses that included depression and anxiety disorder. Review of the most recent Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status score of 13 out of 15, indicating that the Resident is cognitively intact. Further review of the MDS indicated that the Resident takes antipsychotic medications. Review of physician's orders indicated the following:Aripiprazole (an antipsychotic medication) 10 mg (milligrams) once daily for major depressive disorder, single episode, severe without psychotic features, updated 11/21/25. Review of the November 2025 Medication Administration Record (MAR) indicated that the Resident received Aripiprazole daily beginning on 11/14/25. Review of the medical record failed to indicate that an AIMS assessment was completed. During an interview on 11/25/25 at 2:40 P.M., the Director of Nurses said that no AIMS assessment was ever completed on Resident #39. She said that the expectation is that AIMS assessments are completed on admission when a resident is taking an antipsychotic or at the initiation of an antipsychotic medication to monitor for side effects of the medication. During a follow up interview 11/26/2025 8:53 A.M., the Director of Nurses said that there was no specific facility policy for the completion of AIMS assessments.

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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 interviews, the facility failed to maintain medical records in accordance with Nursing professional standards. Specifically, the facility failed to accurately transcribe physician's orders for one Resident (#8) out of a sample of 17 Residents.Findings include:A review of the facility's policy titled ?Charting and Documentation' with a revision date of July 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.-Documentation in the medical record will be objective (not opinionated or speculative), and accurate.Resident #8 was admitted to the facility in January 2025 with diagnoses including dysphagia.Review of the most recent Minimum Data Set (MDS) dated [DATE] did not indicate a Brief Interview Mental Status (BIMS) score because the Resident is rarely/never understood.Further review of the MDS indicated Resident #8 was currently on a feeding tube.Review of a Nutritional Risk assessment dated [DATE] indicated the following:-Diet order/Consistency/Supplement-NPO (Nothing by mouth).Review of a Speech Therapy Evaluation and Plan of Care dated 4/9/25-5/8/25 indicated the following clinical impressions:-Patient is NPO at baseline. [sic]Review of Resident #8's November 2025 physician's orders indicated the following:-Propranolol (a medication used to treat a variety of heart, and circulatory conditions) 10 milligrams (1 tablet) oral three times daily starting 11/13/25, discontinued 11/25/25.Further review of the physician's orders indicated staff administered Propranolol as ordered from 11/13/25 at 2:00 P.M., to 11/25/25 at 2:00 P.M.During an interview on 11/26/25 at 9:12 A.M., Nurse #2 said all of Resident #8's medications should by administered via G-tube (Gastrostomy tube). Nurse #2 said Resident #8 is strictly NPO.During an interview on 11/26/25 at 9:11 A.M., the Dietitian said Resident #8 has been NPO since admission. The Dietitian said he/she should not be receiving medication by mouth.During an interview and medical record review on 11/26/25 at 10:28 A.M., the Director of Nurses and the Surveyor reviewed Resident #8's physician's orders. The DON said Resident #8 is NPO and should not be getting medication by mouth. The DON said the physician's orders were transcribed incorrectly. The DON said she expects physician's orders to be accurately transcribed.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure the arbitration agreement explicitly stated that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. Findings include: Resident #24 was admitted to the facility in October 2025 with diagnoses including metabolic encephalopathy, heart failure and cancer. Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #24 was moderately cognitively impaired, scoring a 12 out of 15 on the Brief Interview for Mental Status exam. Review of the facility document titled Massachusetts Health care Proxy dated 10/1/25 indicated that Resident #24's family member was the designated health care proxy. Review of the facility document titled Activation of Health Care Proxy/Durable Power of Attorney for Health Care, indicated that the health care proxy was activated on 10/15/25. Review of the facility document titled Exhibit C Arbitration Agreement dated April 2025 and signed by Resident #24's health care proxy on 10/23/25, failed to indicate a statement that neither the resident or his/her representative is required to sign the binding arbitration agreement as a condition of admission to, or as a requirement to continue to, receive care at the facility. During an interview on 11/26/25 at 8:05 A.M., the Administrator said she was not aware of the requirement the arbitration agreement must state that neither the resident or his/her representative is required to sign the binding arbitration agreement as a condition of admission to, or as a requirement to continue to, receive care at the facility.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a neutral and fair arbitration process and agree to arbitrator and venue. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure the arbitration agreement provides for the selection of a venue that is convenient to both parties. The binding arbitration agreement must allow for the selection of a venue that is suitable in meeting the needs of both the resident or his or her representative, and the facility. Findings include:Resident #24 was admitted to the facility in October 2025 with diagnoses including metabolic encephalopathy, heart failure and cancer. Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #24 was moderately cognitively impaired, scoring a 12 out of 15 on the Brief Interview for Mental Status exam. Review of the facility document titled Massachusetts Health care Proxy dated 10/1/25 indicated that Resident #24's family member was the designated health care proxy. Review of the facility document titled Activation of Health Care Proxy/Durable Power of Attorney for Health Care, indicated that the health care proxy was activated on 10/15/25. Review of the facility document titled Exhibit C Arbitration Agreement dated April 2025 and signed by Resident #24's health care proxy on 10/23/25 failed to indicate the resident or his/her representative would be provided an opportunity to select a convenient venue. During an interview on 11/26/25 at 8:05 A.M., the Administrator said she was not aware of the requirement the arbitration agreement must state that the resident or his/her representative would be provided an opportunity to select a convenient venue.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to use appropriate infection control practices. Specifically,1. The facility failed to use appropriate hand hygiene and use PPE (Personal Protective Equipment) in a room with Enhanced Barrier Precautions (EBPs) for one Resident (#8) out of a sample of 17 Residents.2. The facility failed to maintain infection control practices consistent with professional standards during the medication pass. Findings include:A review of the facility policy titled 'Enhanced Barrier Precautions with a revision date of March 2024 indicated the following: -Enhanced barrier precautions (EBPs) are utilized to reduce the transmission of multi-drug-resistant organisms (MDROs) to residents. -EBPs employ targeted gown and glove use in addition to standard precautions during high contact care activity (as opposed to before entering the room). -Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include device care or use (feeding tube). CDC (Center for Disease Control) guidelines for donning and doffing gloves indicate the following: To safely don (put on) gloves, you first wash your hands and then put on the first glove, followed by the second, ensuring a snug fit. To doff (take off) gloves, the CDC recommends first removing the first glove by grasping it at the wrist and peeling it off, turning it inside out, while holding it in your other gloved hand. Next, slide your bare fingers under the wrist of the second glove and peel it off, pulling it over the first glove to create a bag with both gloves inside. Immediately perform hand hygiene after removing the gloves. Resident # 8 was admitted to the facility in January 2025 with diagnoses including dysphagia. A review of the most recent Minimum Data Set (MDS) dated [DATE] did not indicate a Brief Interview Mental Status (BIMS) score because the Resident is rarely/never understood. Further review of the MDS indicated that Resident #8 is currently on a feeding tube. On 11/25/25 at 8:25 A.M., the Surveyor observed Resident #8's G-tube (Gastrostomy tube) alarm go off. Nurse #2 came into the Resident's room without a gown on, and a donned a pair of gloves. Nurse #2 straightened out the kink in the feeding tube. Nurse #2 removed his gloves, balled them in a fist, then returned to straighten out the feeding tube one more time without performing hand hygiene and donning a new pair of gloves. Nurse #2 threw the balled gloves in a trash can, left the room, performed hand hygiene outside the room. During an interview on 11/25/25 at 1:47 P.M., Nurse #2 said Resident #8's tube feed alarm goes off often because he/she sleeps on it causing it to bend and form kinks. Nurse #2 said Resident #8's room has Enhanced Barrier Precautions. Nurse #2 said he should have worn a gown prior to entering Resident #8's room. Nurse #2 said he should have performed hand hygiene and donned a new pair of gloves after he took off his gloves and returned to straighten out the feeding tube. During an interview on 11/26/25 at 9:05 A.M., the Infection Preventionist said she expects Nurses to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wear gowns while providing high contact care in rooms with Enhanced Barrier Precautions. The IP said she expects Nurses to perform hand hygiene after doffing gloves, and before donning gloves to provide high contact care. During an interview on 11/26/25 at 9:06 A.M., the Director of Nurses said she expects Nurses to wear a gown prior to entering a room with Enhanced Barrier Precautions if they are going to provide high contact care. The DON said she expects Nurses to perform hand hygiene after doffing gloves and prior to donning a new pair of gloves while providing high contact care. 2. During an observation on 11/26/25 at 9:12 A.M. the surveyor observed Nurse #2 prepare medications for administration for Resident #8. Nurse #2 opened two capsules of Drizalma (an antidepressant medication) with his bare hands and poured the contents into a medication cup for administration to the Resident. During an observation on 11/26/25 at 9:33 A.M., the surveyor observed Nurse #2 prepare medications for administration for Resident #46. Nurse #2 popped two Bumex (a diuretic medication) tablets from the medication card into his bare hands and then placed them in the medication cup for administration to the Resident. During an observation on 11/26/25 at 9:47 A.M., the surveyor observed Nurse #2 prepare medications for administration for Resident #7. Nurse #2 dropped a fish oil capsule onto the medication cart, picked it up with his bare hands and placed it into the medication cup for administration to the Resident. During an interview on 11/26/25 at 9:54 A.M., Nurse #2 said that he should not have touched medications with his bare hands before administering them to the residents. During an interview on 11/26/25 at 10:39 A.M. the Director of Nurses said that nurses should not be touching medications with bare hands when preparing the medications for administration.