

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER COMMONS AT JUDAY CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 17441 SR 23, SOUTH BEND, , 46635					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure survey. Survey Dates: August 25 and 26, 2026 Facility Number: 010667 Residential Census: 23 These deficiencies reflect State Findings cited in accordance with 410 Indiana Administrative Code (IAC) 16.2-3.1. Quality Review completed on 8/31/2026	R 0000					
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and	R 0117	1.What Corrective Action (s) will be accomplished for those residents found to have been affected by the deficient practice: Deficient practice for affected residents was corrected on 9/8/2026. Nursing staff received CPR			09/10/2026	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there was at least one awake staff person with current Cardiopulmonary Resuscitation (CPR) certification, including a hands-on skills competency evaluation, on site during the afternoon and evening shifts for 7 of 7 days reviewed. This deficient practice had the potential to affect 23 of 23 residents who resided in the facility. Findings Include: Review of the nursing schedule	training in classroom by qualified CPR instructor on 9/8/26. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All residents have the potential to be affected by the alleged deficient practice. Executive Director or designee will review employees' files to identify employees who need CPR training in person. 3. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Executive Director, or designee will conduct a full audit to ensure that nursing staff have CPR in accordance with the regulatory requirements. Employees who do not have CPR a hands-on component will be trained by qualified CPR an instructor. 4. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Audits will be completed by Executive Director /designee	
--	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

as worked for August 16 through the 23, 2026 and examination of employee records and CPR certifications, on 8/26/2026 at 9:15 A.M., indicated on all 7 days of the week reviewed, there were no nursing staff member working with a current, approved CPR certification on the second and third shifts. The CPR certifications for all employees indicated it was from an on-line source which did not include a hands on component.

During an interview, conducted with Executive Director (ED) on 8/26/2026 at 0935, she indicated the facility was unaware of the regulatory requirements for the CPR certifications to include a hands on component.

A current policy, dated 10/1/2021 and titled "CPR Status and Certification," was provided by the ED on 8/26/2026. The policy indicated, "...If a resident goes into cardiac and/or pulmonary arrest, it is our policy to call 911 and follow the instructions of the operator. An associate certified in cardiopulmonary resuscitation (CPR) will perform CPR. An associate not certified in CPR will perform Hands-Only CPR if instructed by the 911 operator while waiting for a CPR-certified associate(s) or Emergency First

biweekly for 4 weeks, then bimonthly for 3 months until 100 % accuracy is achieved. If 100 % threshold is not met, then audits will be completed bimonthly until achieve 100 % compliance.

The Administrator or his/her designee will report monthly to the Quality Assurance (QA) committee the ongoing results of audits.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	Responder(s)...."			
R 0123	Personnel - Nonconformance 410 IAC 16.2-5-1.4(h)(1-10) (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and	R 0123	1.What Corrective Action (s) will be accomplished for those residents found to have been affected by the deficient practice; Deficient practice for affected residents was corrected immediately upon identification. Beautician with Michigan licensed stopped immediately working at the community. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the alleged deficient practice. 3. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Executive Director hired Beautician who is licensed by the State of Indiana. She will start her service on 9/9/2026. 4. How the corrective action (s) will be monitored to ensure the	09/10/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	interview, the facility failed to ensure 2 of 2 beauticians had professional licensus in Indiana. This deficient practice had the potential to affect residents who received services in the facility hair salon. Findings include: During a review of personnel files and licenses, on 8/26/2026 at 9:00 A.M., 2 of 2 beauticians' professional licensure documentation indicated their cosmetology license was from Michigan. The record lacked documentation of a current Indiana cosmetology license. During an online review of the Indiana Professional Licensing Agency license search, on 8/26/2026 at 9:15 A.M., the beauticians were not identified as having a current Indiana cosmetology license. During an interview, on 8/26/2026 at 9:20 A.M., the Executive Director confirmed that the beauticians did not have Indiana licensures for cosmetologists. A policy related to cosmetology was requested but not provided prior to the survey exit.		deficient practice will not recur, what quality assurance program will be put into place. Executive Director will verify Beautician license on licensing website to ensure that license is valid for the State of Indiana, Audits will be completed monthly for 3 months until 100 % accuracy is achieved. If 100 % threshold is not met, then audits will be completed monthly until achieve 100 % compliance. Thereafter will monitor monthly and any findings will be reported to QA meeting The Administrator or his/her designee will report monthly to the Quality Assurance (QA) committee the ongoing results of audits.	
R 0274	Food and Nutritional Services - Noncompliance 410 IAC 16.2-5-5.1(g)(1-3)	R 0274	1.What Corrective Action (s) will be accomplished for those residents found to have been	09/10/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

(g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the	affected by the deficient practice; Deficient practice for affected residents was corrected immediately upon identification. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the alleged deficient practice. 3. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Dietary staff were in-serviced on Hair Restraints policy on 9/8/2026. The Director of Food Services or designee will conduct a full audit to ensure food is being served in accordance with the facility's policies and procedures. 4. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Audits will be completed by Director of Food Services /designee biweekly for 4 weeks, then bimonthly for 3 months
--	---

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation. Based on observation, interview and record review, the facility failed ensure food was prepared and served in a sanitary manor for 1 of 1 kitchens reviewed. This deficient practice had the possibility to affect 23 of 23 residents who received their meals from the kitchen. Finding includes: During the kitchen observation on 8/25/2026 at 10:08 A.M., Cook 2 was observed without a beard covering his beard while he was operating the dishwasher. During an observation of the lunch meal service on 8/25/2026 at 12:40 P.M., Cook 2 was not wearing a beard covering on his beard while he plated the lunch time meal for twenty residents. During an interview, on 8/25/2026 at 1:00 P.M., the Dietary Manager indicated she was unsure if a beard cover was required to be worn by staff with beards in the kitchen. On 8/26/2026 at 9:36 A.M., the	until 100 % accuracy is achieved. If 100 % threshold is not met, then audits will be completed bimonthly until achieve 100 % compliance. The Administrator or his/her designee will report monthly to the Quality Assurance (QA) committee the ongoing results of audits.	
--	---	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Executive Director (ED) provided a policy, dated 10/11/2021, and titled, "Hair Restraints". The ED indicated the policy was the one currently used by the facility. The policy indicated, "Hair and beard restraints are placed at both entrances to the kitchen. Hair restraint application is required prior to entering...."			
---	--	--	--

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREBarbara Gaweł	TITLEExecutive Director	(X6) DATE09/08/2026
--	-------------------------	---------------------