STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING _____ B. WING _____	R-C 11/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	**700 E 21ST AVE GARY, IN 46407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the PSR completed on October 6, 2022 to the Investigation of Complaint IN00388228 completed on August 25, 2022. This visit was in conjunction with the PSR to the Recertification and State Licensure Survey completed on October 6, 2022. This visit was in conjunction with the Investigation of Complaint IN00395536. Complaint IN00388228 - Corrected. Complaint IN00395536 - Unsubstantiated due to lack of evidence. Survey date: November 28, 2022. Facility number: 000368 Provider number: 155845 AIM number: 100275220 Census Bed Type: SNF/NF: 23 Total: 23 Census Payor Type: Medicaid: 21 Other: 2 Total: 23 Simmons Loving Care Health Facility was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the PSR to the Investigation of Complaint IN00388228.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	Continued From page 1 Quality review completed on 11/30/22.	{F 000}		