| 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 _____ | 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<br><br>This visit was for the Investigation of Complaint IN00395536.<br><br>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on October 6, 2022.<br><br>This visit was in conjunction with a PSR to the PSR completed on October 6, 2022 to the Investigation of Complaint IN00388228 completed on August 25, 2022.<br><br>Complaint IN00395536 - Unsubstantiated due to lack of evidence.<br><br>Complaint IN00388228 - Corrected.<br><br>Survey date: November 28, 2022.<br><br>Facility number: 000368<br>Provider number: 155845<br>AIM number: 100275220<br><br>Census Bed Type:<br>SNF/NF: 23<br>Total: 23<br><br>Census Payor Type:<br>Medicaid: 21<br>Other: 2<br>Total: 23<br><br>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 Investigation of Complaint IN00395536. | 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<br>Quality review completed on 11/30/22. | F 000 | | |