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 12/21/2021

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 Recertification and State Licensure Survey completed on October 29, 2021. This visit included the PSR to Complaint IN00362987 completed on October 29, 2021. This visit was in conjunction with the PSR to the Investigation of Complaint IN00359414 completed on August 9, 2021. This visit was in conjunction with the Investigation of Complaint IN00366676. Complaint IN00362987 - Corrected. Survey dates: December 20 and 21, 2021 Facility number: 000368 Provider number: 155845 AIM number: 100275220 Census Bed Type: SNF/NF: 16 Total: 16 Census Payor Type: Medicaid: 15 Other: 1 Total: 16 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 Recertification and State Licensure Survey and the PSR to the Investigation of Complaint IN00362987.	{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
	155845	A. BUILDING _____ B. WING _____	R-C 12/21/2021

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{F 000}	Continued From page 1 Quality review completed on 12/22/21.	{F 000}		
{F9999}	FINAL OBSERVATIONS	{F9999}		