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 07/17/2023

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 the Post Survey Revisit (PSR) to the Investigation of Complaint IN00409942 completed on June 13, 2023. This visit was in conjunction with the PSR to the Investigation of Complaint IN00404677 completed on March 23, 2023. This visit was in conjunction with the PSR to the Recertification and State Licensure Survey and the PSR to the Investigation of Complaints IN00404632 and IN00404731 completed on April 5, 2023. This visit was in conjunction with the Investigation of Complaint IN00412259. This visit resulted in a Partially Extended Survey - Substandard Quality of Care. Complaint IN00404632 - Not corrected. Complaint IN00404731 - Not corrected. Complaint IN00404677 - Not corrected. Complaint IN00409942 - Corrected. Complaint IN00412259 - Federal/State deficiencies related to the allegations are cited at F567, F568, F570, F582, and F602. Survey dates: July 13, 14, and 17, 2023 Facility number: 000368 Provider number: 155845 AIM number: 100275220	{F 000}		

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

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.

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 Census Bed Type: SNF/NF: 20 Total: 20 Census Payor Type: Medicaid: 17 Other: 3 Total: 20 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 Investigation of Complaint IN00409942. Quality review completed on 7/19/23.	{F 000}		