

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

PRINTED: 05/30/2025  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>152521</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                            |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>05/20/2025</b> |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>COMPREHENSIVE RENAL CARE- GARY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4802 BROADWAY</b><br><b>GARY, IN 46408</b>                          |                      |                                                                 |
| (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 |                                                                 |
| V 000                                                                     | <p>INITIAL COMMENTS</p> <p>This visit was for a Federal complaint survey of an ESRD Provider.</p> <p>Survey Date: May 20, 2025</p> <p>Complaint: IN00457269 was investigated; no Federal deficiencies were cited.</p> <p>Census: 62</p> <p>Comprehensive Renal Care Gary was found to be in compliance with 42 CFR 494.70, 494.90, and 494.110 as is related to this Federal Complaint survey.</p> <p>QR: 5/30/2025</p> | V 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.