

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

PRINTED: 12/08/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155530</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>12/05/2023</b>	
NAME OF PROVIDER OR SUPPLIER  <b>SOUTH SHORE HEALTH &amp; REHABILITATION CENTER</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>353 TYLER ST</b> <b>GARY, IN 46402</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
{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00415780 completed on September 28, 2023.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00420236, IN00421350, and IN00421372.</p> <p>Complaint IN00415780 - Corrected.</p> <p>Complaint IN00420236 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00421350 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00421372 - No deficiencies related to the allegations are cited.</p> <p>Survey date: December 5, 2023</p> <p>Facility number: 000369 Provider number: 155530 AIM number: 100275190</p> <p>Census Bed Type: SNF/NF: 79 Total: 79</p> <p>Census Payor Type: Medicare: 7 Medicaid: 67 Other: 5 Total: 79</p> <p>South Shore Health and Rehabilitation Center was found to be in compliance with 42 CFR Part</p>			{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.

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{F 000}	Continued From page 1 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00415780.  Quality review completed on 12/7/23.	{F 000}			