STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. BUILDING _____ B. WING _____	C 07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNSHIRE HEALTH & REHABILITATION CENTER	**8380 VIRGINIA ST MERRILLVILLE, IN 46410**

(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 Investigation of Complaints IN00355524, IN00356140 and IN00357186. Complaint IN00355524 - Unsubstantiated. Allegation did not occur. Complaint IN00356140 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00357186 - Substantiated. No deficiencies related to the allegations are cited. Survey date: 7/1/21 Facility number: 000577 Provider number: 155650 AIM number: 100266950 Census Bed Type: SNF/NF: 70 Total: 70 Census Payor Type: Medicare: 15 Medicaid: 44 Other: 11 Total: 70 Lincolnshire Health and Rehabilitation Center 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 Complaints IN00355524, IN00356140 and IN00357186. Quality review completed on 7/2/21.	F 000		

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