	T OF HEALTH AND HU R MEDICARE & MEDIO				FORM APPROVED OMB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155222	B. WING		05/17/2016
NAMEOE	PROVIDER OR SUPPLIE	D	STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	FROVIDER OR SUFFLIE	IX		LINCOLN RD	
KINDRE	D TRANSITIONAL	CARE AND REHAB-KOKOMO	КОКО	MO, IN 46902	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
= 0000					
Bldg. 00					
Blag. 00	This visit was f	or the Investigation of	F 0000	Thefacility requests that this	
	Complaint IN00	-	1 0000	plan	
				Ofcorrection be considered its	
	Complaint INO	)199457 - Substantiated.			
	· ·	eficiencies related to		Credibleallegations of	
				compliance.	
	anegations are o	cited at F164 and F425.		Submissionof this response	
	C latan I	4. 16. 117. 2016		and Plan	
	Survey dates: I	May 16 and 17, 2016		OfCorrection is not a legal	
	<b>D</b> 11/ 1	000127		admission that a	
	Facility number			Deficiencyexists or that this	
	Provider number			statement of	
	AIM number:	100291430		Deficiencywas correctly cited	
				and is also not	
	Census bed type	e:		Tobe construed as an	
	SNF/NF: 59			admission of interest	
	Total: 59			Against the facility, the	
				Administrator or employee,	
	Census payor ty	/pe:			
	Medicare: 10			Agents, or other individuals	
	Medicaid: 38			who draft or may be	
	Other: 11			Discussedin the response and	
	Total: 59			Plan of Correction in	
				Addition, preparation and	
	Sample: 8			submission of the Plan of	
				Correctiondoes not constitute	
	These deficienc	eies reflect State finding		an admission or	
		ince with 410 IAC		Agreementof any kind by the	
	16.2-3.1.			facility of the truth of	
				Anyfacts alleged or the	
	OR completed	by 14466 on May 18,		corrections of conclusions set	
	2016.	<i>i i j i i i i i i i i i i i i i i i i i</i>		Forthin this allegation by the	
	2010.				
	I	VIDER/SUPPI IER REPRESENTATIVE'S SI	1	TITI F	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED:

06/08/2016

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155222	B. WING		05/17/2016
NAME OF 1	PROVIDER OR SUPPLIE	R	STREE	T ADDRESS, CITY, STATE, ZIP COD	E
				V LINCOLN RD	
KINDRE	D TRANSITIONAL	CARE AND REHAB-KOKOMO	KOKO	DMO, IN 46902	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	COPRIATE
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
				survey agency.	
				Accordingly, the facility ha	as
				prepared and submitted	
				ThisPlan of Correction pri	or to
				the resolution of appeal of	of
				Thismatter solely because	e of
				the requirements under	
				Stateand Federal law that	t
				mandates submission of t	the
				Planof Corrections a conc	lition
				to participate in the Title	
				18and Title 19 programs.	The
				submission of Plan of	-
				Correctionwithin this	
				timeframe should in no w	/av
				be	
				Ofnon-compliance or	
				admission by the facility.	
0164	483.10(e), 483.7				
SS=D	OF RECORDS	VACY/CONFIDENTIALITY			
Bldg. 00		the right to personal			
		dentiality of his or her			
	personal and clin	ical records.			
	Personal privacy	includes accommodations,			
		it, written and telephone			
		personal care, visits, and			
	-	y and resident groups, but			
		uire the facility to provide a			
	private room for				
	Except as provid	ed in paragraph (e)(3) of			
	this section, the r	esident may approve or			
		e of personal and clinical			
	records to any in	dividual outside the facility.			

STATEME	NT OF DEFICIENCIES	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	î ź	ILDING	DNSTRUCTION 00	(X3) DATE COMPL 05/17	LETED
	PROVIDER OR SUPPLIE	R CARE AND REHAB-KOKOMO		429 W I	ADDRESS, CITY, STATE, ZIP CODE LINCOLN RD 10, IN 46902	1	
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
	personal and clin when the residen health care institu required by law. The facility must information conta records, regardle methods, except transfer to anothe law; third party pa resident. Based on record interview, the fa privacy of a resi not placed on So	ht to refuse release of ical records does not apply t is transferred to another ution; or record release is keep confidential all ined in the resident's ss of the form or storage when release is required by er healthcare institution; ayment contract; or the I review, observation, and acility failed to ensure the ident was maintained and ocial Media for 1 of 3 ed for privacy. (Resident	F 01	64	We respectfully reques adesk review for paper compliance for this	t	06/03/20
	I) Finding include				citation. F164 Personal Privacy/Confidentiality	,	
	During an interv Director (ED) of she indicated En- terminated for p resident on a Fa following Police to HIPAA (Hea and Accountabi personal inform during the invest indicated they h	view with the Executive n 5/17/16 at 10:02 a.m., mployee #1 was recently oosting a photo of a cebook page, not les and Procedures related alth Insurance Portability lity Act) (Security of ation). The ED indicated utigation the employee ad the resident and ion to take the picture.			of Records The resident identified wasdeceased at the time the photo was posted to social media so was not affected. Since all residents havethe potential to be affected by the same deficient practice, KindredCommunication		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAR CERVIA

ENTERS FOR MEDIC		CAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/17/2016
NAME OF PROVIDE		R CARE AND REHAB-KOKOMO	429 W	address, city, state, zip code LINCOLN RD MO, IN 46902	
	EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
Com dated state fami infor emp the p The Emp Resi Resi the p indic Febr resid The until are v Emp facil post The on 5, not c away	apliance for d 5/17/16, in ed they had p ily to take the rmation cou- loyee agreed post from the facility inve- bloyee #1 had dent #H on ident #H had post on 5/17 cated the pice coury 4, 201 dent sitting in caption on the l another day way." bloyee #1 was hity was made and terminal record for F /17/16 at 1: cognitively in Federal tag 0199457.	the Kindred Cooperation indicated the employee permission from the ne photo, but this ld not be confirmed. The d on 5/5/16, to remove eir Facebook page. estigation indicated ad posted a picture of their Facebook page after d passed. Observation of /16 at 1:00 p.m., cture was posted on 6. The picture was of the n a wheelchair, smiling. the page stated, "Fly away y soon soon we will be on as suspended when the de aware of the Facebook ated on 5/12/16. Resident #H was reviewed 10 p.m. The resident was impaired and had passed		s Dept. monitors social media for inappropriat use and notifiesthe Executive Director of activity and identity of employee involved. To ensure the deficientpractice does not occur again, all ne employees will be educated duringorientation on Kindred Communications Polic specifically outlined in EmployeeHandbook a "Standard of ConductRegarding Communication", as well as "Resident Information Protected by HIPPA."Staff will be educated onreporting inappropriate posting resident information	l te w w

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Event ID:

HOEQ11 Facility ID: 000127

If continuation sheet

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STATEMEN	MEDICARE & MEDI	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	(X2) MULTIPLE C A. BUILDING B. WING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 05/17/2016	
	NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO			ADDRESS, CITY, STATE, ZIP CODE LINCOLN RD MO, IN 46902	
(X4) ID		STATEMENT OF DEFICIENCIES			(X5)
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLET
				found on social media.	
				To ensure	
				deficientpractice will	
				not recur, all staff will	
				be in-serviced on,	
				"Safeguards:Verbal	
				Uses and Disclosures of	of
				Protected Health	
				Information," and	
				"Safeguards: Social	
				Media."All new	
				employees will be	
				educated	
				duringorientation on	
				Kindred	
				Communications Polic	y
				specifically outlined in	
				EmployeeHandbook a	s
				"Standard of	
				ConductRegarding	
				Communication", as	
				well as	
				"ResidentInformation	
				and Information	
				Protected by	
				HIPPA."Staff will be	

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	(X2) MUI A. BUII B. WIN	LDING	onstruction 00	(X3) DATE COMPI <b>05/17</b>	LETED
NAME OF PI	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
KINDRED	TRANSITIONAL	CARE AND REHAB-KOKOMO			LINCOLN RD MO, IN 46902		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	Γ		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	Р	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					educated on reporting		
					inappropriate posting of	of	
					residentinformation to		
					social media. Any		
				reports of inappropriat	e		
					resident		
					privacyviolation will be		
					investigated by		
					corporate manager of		
					HIPPA Compliance.		
					Tomonitor, the		
					Executive Director		
					and/or designee will		
					audit 3 employees		
					weekly for 4 weeks,		
					then 5employees		
					monthly for 6 months		
					on their understanding	ŗ	
					of, "Safeguards:Verbal		
					Uses and Disclosures o		
					Protected Health		
					Information" and		
					"Safeguards:Social		
					Media."Executive		
					Director and/ordesigne		
					will report finding to th	ie	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/17/2016	
	PROVIDER OR SUPPLIE	R CARE AND REHAB-KOKOMO	429 V	i address, city, state, zip code / LINCOLN RD DMO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIO DATE	
				PI committee monthly times 6 months.		
				June 3, 2016 systemic		
				changes will be completed.		
<sup>-</sup> 0425 SS=E Bldg. 00	PROCEDURES, The facility must emergency drugs residents, or obta agreement descri part. The facility personnel to adm permits, but only supervision of a li A facility must pro- services (includin	provide routine and and biologicals to its in them under an bed in §483.75(h) of this may permit unlicensed inister drugs if State law under the general censed nurse. wvide pharmaceutical g procedures that assure				
	and biologicals) to resident. The facility must of services of a licer	arring, receiving, administering of all drugs o meet the needs of each employ or obtain the used pharmacist who tion on all aspects of the				
	provision of pharm Based on record the facility faile were available f 5 residents revie	nacy services in the facility. review and interview, d to ensure medications or administration for 4 of ewed for medication esident #C, #E, #H, and	F 0425	Werespectfully request a desk review for paper compliance for this citation. <b>F425 Pharmaceutical</b> <b>Services-AccurateProcedures</b> Allmedication orders have been reviewed for affected Residents C, E, H, andD.Currently all their		

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

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G <u>00</u>	COM	te survey Mpleted 17/2016		
	PROVIDER OR SUPPLIE	R CARE AND REHAB-KOKOMO	429	STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902				
X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES	ID PREFIX	CROSS-REFERENCED TO TH	N SHOULD BE	(X5) COMPLETION		
TAG	Findings include 1. The record for reviewed on 5/1 Diagnoses inclu- to, diabetes mellow Current physicia Prilosec 20 milli (esophageal reflow ASA 81 mg dailing Lasix 20 mg dailing duloxetine HCL daily (depression Claritin 10 mg composition Progress notes and Administration 5/14/16; indicate medications were administration: 5/14/16: ASA ( (mg), Lasix 20 mg, administration. 5/11/16: Lasix 10 Prilosec 20 mg, administration. Medication had 5/8/16: Prilosec	or Resident #C was 6/16 at 10:43 a.m. ded, but were not limited litus and cancer. an orders indicated: igrams (mg) daily ux) ly (Thrombus) ly (swelling) . 30 mg 3 caps by mouth n) laily (allergies) and the Medication Record (MAR) dated ed the following re unavailable for Aspirin) 81 milligrams ng, Claritin 10 mg, for the a.m., 20 mg, ASA 81 mg, , for the a.m., note indicated the	TAG	medications are available administered asordered. Since allresidents receivin medications have the por affected, an audit hasbeet completed to ensure all medication orders are available toensure this does not re- licensed nursing staff, as QMAs, will be in-serviced and procedures for, 1)me unavailability, including appropriatedocumentati progress notes 2) PointO reordering protocol. Automaticreplacement of Emergency Drug Kits 3 til week will be implemented more commonly used dru available 24/7 if needed. Monitoring of emar prog by Directorof Nursing and designee will be implemented per week to ensuremedid available. Any unavailabl indentified from the daily be tracked on weekly aud identify trends. Director of and/or designee will report to PI committee monthly 6months. June 3,2016 systemic char becompleted.	ng tential to be en residents' vailable. <b>plemented</b> ecur, all well as d onpolicy edication fon in Click Care of mes per ed toensure ugs are gress notes d/or ented 5 days cations are le meds yreview will dit tool to ofNursing ort findings r times	DATE		

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Event ID: HOEQ11 Facility ID: 000127

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	A. B	ULTIPLE CC UILDING /ING	00	COM	(X3) DATE SURVEY COMPLETED 05/17/2016	
	NAME OF PROVIDER OR SUPPLIER			STREET A 429 W I KOKON	CODE			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE /	HOULD BE	(X5) COMPLETIO	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	20 mg, ASA 81 a.m., administra							
		Lit" (Emergency Drug kit) y the DON on 5/17/16 at						
	-	cated ASA 81 mg,						
	-	Lasix 20 mg, and Claritin						
	10 mg were avai	ilable for administration.						
	-	ork With Order Fill"						
		Claritin 30 tabs were						
		9/16 and 5/14/16, which						
	indicated a short	t fall in availability.						
	2. The record for	or Resident #C was						
	reviewed on 5/1	6/16 at 11 a.m.						
	Current Physicia	an orders indicated:						
	Claritin Capsule	10 mg daily (allergies)						
		nicrograms daily						
	(supplement)							
	Tab a vite daily							
	Reflux)	wice daily (Esophageal						
	Progress notes a	nd the MAR (Medication						
		Record) for the following						
		nedications were not						
	available for adr	ninistration:						
	5/15/16: Prilose	ec 20 mg at 8:00 p.m.,						

	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	, í		COM 05/1	(X3) DATE SURVEY COMPLETED 05/17/2016	
	NAME OF PROVIDER OR SUPPLIER			429 W L	ddress, city, state, zip c INCOLN RD IO, IN 46902	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETH DATE
	5/14/16: Tab-a- Claritin 10 mg a	vite, Prilosec 20 mg and t 8:00 a.m.					
	5/11/16: Tab-a- 8:00 a.m.	vite, Prilosec 20 mg at					
	5/8/16: Prilosec	20 mg 8:00 a.m.					
	5/7/16: Prilosec	20 mg 8:00 a.m.					
	5/3/16: Folic A	cid a.m. administration					
	5/17/16 at 10:50 20 mg, Folic Ac	it (Emergency provided by the DON on a.m., indicated Prilosec id and Claritin 10 mg r administration to the					
	indicated Folic A on 4/2/16 and 5/ one day delay in 20 mg, 30 tabs v and 60 tabs on 4 tabs was ordered	York with Order Fills' Acid 30 tabs was shipped (3/16. This would be a a administration. Prilosec was shipped on 3/15/16, //1/16. Claritin 10 mg 30 d on 5/10/16, canceled, on 5/13/16 and shipped on					
		or Resident #D was 6/16 at 1:04 p.m.					
	-	s for April 2016, er for chloridiasepoxide					

NTERS FOR MEDICARE & MEDICAID SERVICES						L L	MB NO. 0938-03
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	A. I	MULTIPLE CO BUILDING WING	DNSTRUCTION 00	СОМ	e survey pleted <b>7/2016</b>
NAME OF	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP	CODE	
KINDRE	D TRANSITIONAL	CARE AND REHAB-KOKOMO		429 W KOKON			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	COMPLETI
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
	HCL 10 mg 2 tin schizophrenia.	ines dany for					
	The April Medie	cation Administration					
	Record (MAR) i was unavailable	indicated the medication on $4/9/16$ .					
		ork With Order Fills" edication 30 tabs was					
	shipped on 3/31	/16 an 4/13/16, and					
	should have bee	n available for					
	administration.						
		or Resident #H was 6/16 at 12:53 p.m.					
	Current physicia	an orders indicated:					
	donepexil 5 mg dementia.	1 tab daily at bedtime for					
		and the MAR (Medication					
		Record) indicated					
	medication was following date:	unavailable on the					
	5/15/16: donepe	zil HCL 5 milligrams					
	(mg)						
		Kit" (emergency drug kit)					
		DON on 5/1/7/16 at					
	10:50 a.m., indi	cated the medication was					
	available for adr						

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> B. WING		COMPLETED 05/17/2016		
	PROVIDER OR SUPPLIE	CARE AND REHAB-KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902				
X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETIC DATE		
	5/17/16 at 11:1:	view with the DON on 5 a.m., she indicated she medications were administration.					
	Pharmacy) phar 11:46 a.m., she	view with the (Name of rmacist on 5/17/16 at indicate mediation ad not been a trend here at					
	provided by the a.m., and deem indicated: "P discovery that I supply of a med resident, Facilit immediately in medications fro next available of missed dose in schedule, Facilit medication from	vailable Medications" was DON on 5/17/16 at 10 ed as current. The policy rocedure: 1. Upon Facility has an inadequate lication to administer to a					

3.1-25(a)

IN00199457.

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Event ID: HOEQ11 Fa

EQ11 Facility ID: 000127

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DEPARTMENT OF HEALTH AND HUMAN SERVICES         CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA       X2) MULTIPLE CONSTRUCTION         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       00         155222       B. WING					FO OM (X3) DATE COMPI	PRINTED:         06/08/2016           FORM APPROVED         000000000000000000000000000000000000	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO			STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	

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