

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

PRINTED: 10/27/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155133</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/20/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2100 MIDWAY ST</b> <b>COLUMBUS, IN 47201</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>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00184702.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on August 27, 2015.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaint IN00180480 completed on August 27, 2015.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaints IN00181773 and IN00181885 completed on September 18, 2015.</p> <p>Complaint IN00184702 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: October 19 &amp; 20, 2015</p> <p>Facility number: 000058 Provider number: 155133 AIM number: 100283340</p> <p>Census bed type: SNF/NF: 125 Total: 125</p> <p>Census payor type: Medicare: 17 Medicaid: 95 Other: 13 Total: 125</p> <p>Sample: 3</p> <p>Kindred Transitional Care and Rehab - Columbus</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 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 Complaint IN00184702, the PSR to the Recertification and State Licensure Survey, the PSR to the Investigation of Complaint IN00180480, and the PSR to the Investigation of Complaints IN00181773 and IN00181885.  QR completed by 34849 on October 26, 2015.	F 000		