

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

PRINTED: 11/10/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155334</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>11/07/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7301 E 16TH ST</b> <b>INDIANAPOLIS, IN 46219</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 a Post Survey Revisit (PSR) to the Investigation of Complaints IN00208525 and IN00210221 completed September 20, 2016.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00210492 and IN00213658.</p> <p>Complaint IN00208525-Corrected</p> <p>Complaint IN00210221-Corrected</p> <p>Complaint IN00210492-Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00213658-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: November 4, 6, and 7, 2016</p> <p>Facility number: 000227 Provider number: 155334 AIM number: 100267520</p> <p>Census bed type: SNF/NF: 140 Total: 140</p> <p>Census payor type: Medicare: 21 Medicaid: 102 Other: 17 Total: 140</p> <p>Sample: 3</p> <p>Kindred Transitional Care and Rehabilitation-Wildwood was found to be in compliance with 42</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.

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

PRINTED: 11/10/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155334</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>11/07/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7301 E 16TH ST</b> <b>INDIANAPOLIS, IN 46219</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}	Continued From page 1 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaints IN00208525 and IN00210221.  Quality review completed by 30576 on November 9, 2016	{F 000}		