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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155334	A. BUILDING ______ B. WING ______	C 11/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD	7301 E 16TH ST INDIANAPOLIS, IN 46219

(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	F 000		

INITIAL COMMENTS

This visit was for the Investigation of Complaints IN00210492 and IN00213658.

This visit was in conjunction with the Post Survey Revisit (PSR) to Complaints IN00208525 and IN00210221 completed on September 20, 2016

Complaint IN00210492- Unsubstantiated due to lack of evidence.

Complaint IN00213658- Substantiated. No deficiencies related to the allegations are cited.

Complaint IN00208525-Corrected

Complaint IN00210221-Corrected

Survey dates: August 4, 6, and 7, 2016

Facility number: 000227
Provider number: 155334
AIM number: 100267520

Census bed type:
SNF/NF: 140
Total: 140

Census payor type:
Medicare: 21
Medicaid: 102
Other: 17
Total: 140

Sample: 3

Kindred Transitional Care and Rehabilitation-Wildwood was found to be in compliance with 42

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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KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD	**7301 E 16TH ST** **INDIANAPOLIS, IN 46219**

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F 000	Continued From page 1 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00210492 and IN00213658. Quality review completed by 30576 on November 9, 2016	F 000		