STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155334	A. BUILDING 00 B. WING	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILDWOOD HEALTHCARE CENTER	7301 E 16TH ST INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00397957, IN00397001, IN00399261, IN00392354, IN00394658, IN00395905, IN00396160, IN00396983, and IN00401802. Complaint IN00397957 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00397001 - Substantiated. Federal/State deficiencies related to the allegations are cited at F774. Complaint IN00399261 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00392354 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00394658 - Unsubstantiated due to lack of evidence. Complaint IN00395905 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00396160 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00396983 - Substantiated. Federal/State deficiencies related to the allegations are cited at F774. Complaint IN00401802 - Substantiated. Federal/State deficiencies related to the allegations are cited at F812 and F926. Survey dates: February 13, 14, 15 and 16, 2023	F 0000	On February 16, 2023 a complaint survey from ISDH completed a Complaint Survey at Wildwood Healthcare. Enclosed please find the stated list of deficiencies with the facility's plan of correction for these alleged deficiencies. Please consider this letter and plan of correction to be the facility's credible allegation of compliance. This letter is our request for a desk review/ paper compliance to verify the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the plan of correction as March 20, 2023 Respectfully Ethan Peak, Executive Director	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ethan Peak	Executive Director	03/13/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Facility number: 227 Provider number: 155334 AIM number: 100267520 Census Bed Type: SNF/NF: 148 Total: 148 Census Payor Type: Medicare: 11 Medicaid: 128 Other: 9 Total: 148 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 23, 2023			
F 0774 SS=D Bldg. 00	483.50(a)(2)(iii) Assist w/ Transport Arrangements to Lab Srvcs §483.50(a)(2) The facility must- (iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance. Based on interview and record review, the facility failed to follow their resident transportation policy when assisting a resident in making transportation arrangements to and from a physician's visit for 1 of 3 residents reviewed for assistance with transportation needs. (Resident B) Findings include: The clinical record for Resident B was reviewed on 2/14/23 at 2:52 p.m. Resident B's diagnoses included, but not limited to, vascular dementia	F 0774	1) Resident B was not harmed by the deficient practice and appointment was rescheduled. 2) All residents with scheduled MD appointments have the potential to be affected. An audit was conducted of upcoming MD appointments to ensure that all residents with appointments have transportation arrangements completed. Any resident with	03/20/2023

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	with behavioral disturbance, anxiety disorder, and delirium. Resident B's quarterly MDS (minimum data set) dated 1/26/23 indicated, Resident B's cognitive ability was unable to be established; and she required extensive assistance of two persons for bed mobility, transfers, and toileting. A physician's order dated 11/28/22 indicated, Resident B had an appointment with her cardiologist on 11/28/22 at 2:20 p.m. and must have staff to go with her to assist. A nursing note dated 11/30/22 at 8:51 a.m. indicated, when the writer of the note called the cardiologist office to inform them of a recent lab result and attempted to reschedule the cardiology appointment, the cardiologist office stated, "If something opens up sooner I'll call you, but right now I just don't have anything available." An interview with UM (unit manager) 4 was conducted on 2/14/23 at 3:21 p.m. UM 4 indicated, she was the nurse who had spoke to the cardiologist's office on 11/30/22. When asked if Resident B went to her cardiologist appointment on 11/28/22 she indicated, Resident B often has "sun downing" (a state of confusion occurring in the late afternoon and lasting into the night often with different behaviors, such as confusion, anxiety, aggression or ignoring directions among others) and can be resistant to care and she may have been having a sun downing episode that day and can become combative when in that state. An interview with Resident B's cardiologist's office was conducted on 2/14/23 at 3:30 p.m. indicated, Resident B was a no call/no show for her appointment on 11/28/22.		appointments that have refusals will be addressed per facility policy. 3) All licensed nursing staff and IDT team were educated on facility policies “Refusal of Care and Treatment” and “Resident Transportation”. 4) The transportation schedule will be reviewed 5 days per week x 30 days, then 3 days per week x 30 days, then weekly x 4 months in the morning clinical meeting to ensure residents appointments are documented as having attended the appointment or if they did not documentation reflecting the reason why the appointment was not attended. ¿	

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	Resident B's progress notes did not contain information regarding if/when she went to the cardiology appointment on 11/28/22 nor did it contain information regarding a possible change in condition or refusal. An interview with MR (medical records manager) 9, who also assists to set up transportation for residents' appointments, was conducted on 2/15/23 at 2:05 p.m. MR 9 indicated, if a resident refuses to go to an appointment, the nurse should place a nursing note in the progress notes with the reason for the refusal. She admitted, the facility has had issues when the transportation provider call and cancels the day of the appointment. She indicated, if that happens, nursing should document such an issue in progress notes. A Refusal of Care and Treatment policy was received on 2/14/23 at 3:43 p.m. The policy indicated, "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs of the residents...Procedure...c. The facility will make considerations for resident to the extent possible who are cognitively impaired and attempt to determine the reason for the refusal and provide potential solutions...iii. Document attempts at solutions in progress notes...IV. Document...b. Attempts made to resolve the refusal including but not limited to other routes, other times, other methods that the resident is in agreement with..." A Resident Transportation policy was received on 2/13/23 at 2:32 p.m. The policy indicated, "Policy...The facility will assist the resident in making transportation arrangements to and from the source of any needed			

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	service...Procedure...D...1. Provide an escort with a cell phone, as needed to contact the facility in event of an emergency...F. Document the time of expected departure and the expected time of arrival back to facility. G. Nursing will document time of leaving the unit and the time the resident returns to the unit." This Federal tag relates to complaints IN00397001 and IN00396983. 3.1-49(f)(3)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to ensure food was	F 0812	1. 1. No residents here harmed by	03/20/2023

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	stored and prepared under sanitary conditions related to: trash cans not having tight fitting lids; not labeling, dating, and/or covering items in coolers; not ensuring foods are not expired; foods not in original containers not clearly labeled for contents, dated or stored with tight fitting lids; kitchen staff not wearing beard protectors in the kitchen; and not ensuring general cleanliness of the kitchen for 147 of 148 residents served meals from the kitchen. Findings include: A brief kitchen tour was conducted on 2/15/23 at 11:28 a.m. with DS (dietary staff) 2. During the kitchen tour, the following was observed: In the main kitchen area was: -DS 3 was preparing salads while not wearing a beard guard or face mask while in the kitchen and his beard/mustache was longer than 1/4 inches. -DS 2 had dreadlocks which were hanging past his shoulders and was wearing a hair net that did not cover all of his hair. -An uncovered trash can was next to the prep table that was not being used at the time. -The floor was littered with debris such as old french fries, opened sweetener packets, and unidentifiable black debris under prep tables, stove, bulk bins, steam table, and caked in corners. -Crumbs on shelves under prep tables with clean pans and baking ware. -Bulk storage of brown sugar and white sugar bin's lid cracked and missing a piece leaving contents open to air and debris. In the dry goods room was a serving tray with 6 covered bowls without a label or dates. DS 2 identified the contents in the bowls as cereal.		this deficient practice. 2. All residents who eat from the kitchen have the potential to be affected by this deficient practice. The listed items have been corrected by the dietary manager. All trash cans have fitting lids, all food that was not labeled or dates has been thrown out, all items in cooler are now covered- the egg lid cover was closed, the expired buttermilk has been thrown away, the sugar has been placed into new containers, staff are wearing hair and beard nets with their hair off the shoulders and daily cleaning duties have been assigned and completed. 3. All dietary staff will be educated on label/dating of foods, ensuring all expired foods are thrown out, covering items, beard and hair net usage with hair off shoulders, using trash can lids and general cleanliness with cleaning duties. 4. Executive Director or designee will audit kitchen 5 x's per week for 30 days, then 3 times x per week for 30 days, then 10 times per month for 4 months or until 100% compliance is achieved.	

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	In the refrigerator was: -A metal pan with a lid without a label or date. The contents of the pan looked like sawdust but was identified as pulled pork. -3 half gallons of buttermilk with expiration dates of 2/1/23. -A large bucket of whole peeled eggs with the lid peeled up on one corner leaving the contents open to air. On a shelf under the steam table was a large, white bucket containing a yellow, milky fluid. There was a green hose going from the bucket up to the drain from the steam table and a crusty yellow/brown stained towel wrapped around a pipe sitting on the shelf. An interview with DS 3 during the tour, indicated, the steam table drain has a leak and that is why there was a towel wrapped around the pipe on the shelf and since there is a leak in the pipe they are now using the green hose and bucket to drain the steam table. A Food: Preparation policy was received on 2/15/23 at 2:27 p.m. from ED. It indicated, "2. Dining services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination...17. All TCS [sic, time/temperature control for safety) foods that are to be held for more than 24 hours...will be labeled and dated with a 'prepared date'...and a 'use by date". A Staff Attire policy was received on 2/15/23 at 2:27 p.m. from ED. It indicated, " 1. All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained".			

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	The Indiana Retail Food Manual indicated, "410 IAC 7-24-174 Food storage containers; identified with common name of food Sec. 174. (a) Working containers holding food or food ingredients that are removed from their original packages for use in the retail food establishment, such as: (1) cooking oils; (2) flour; (3) herbs; (4) potato flakes; (5) salt; (6) spices; and (7) sugar; shall be identified with the common name of the food, except that containers holding food that can be readily and unmistakably recognized, such as dry pasta, need not be identified...410 IAC 7-24-392 Covering receptacles Sec. 392. (a) Receptacles and waste handling units for refuse, recyclables, and returnable's shall be kept covered: (1) inside the retail food establishment if the receptacles and units: (A) contain food residue and are not in continuous use; or (B) after they are filled; and (2) with tight-fitting lids or doors if kept outside the retail food establishment." This Federal tag relates to complaint IN00401802. 3.1-21(i)(3)			
F 0926 SS=E Bldg. 00	483.90(i)(5) Smoking Policies §483.90(i)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety			

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	that also take into account nonsmoking residents. Based on observation, interview, and record review, the facility failed to implement the facility smoking policy by not assuring residents did not share smoking materials, not assuring a resident was supervised and wore a safety smoking apron, as assessed, while smoking, not assuring a resident using oxygen was not in the area of a resident who was smoking, not providing functional safety ashtrays on stable surfaces in the designated smoking area, not assuring resident extinguished cigarettes in proper receptacles, and not assuring that residents' smoking materials were stored by the facility, per policy, for 4 of 4 residents reviewed for smoking (Resident C, D, E, and F). Findings include: 1. The clinical record for Resident C was reviewed on 2/15/23 at 11:15 a.m. The Resident's diagnosis included, but were not limited to, weakness and diabetes. A Smoking Assessment, dated 11/24/22, indicated she used cigarettes and that she smoked between 6 and 10 times daily. She was able to light her own cigarettes and to dispose of cigarettes appropriately. She was independent with smoking. A Quarterly MDS (Minimum Data Set) Assessment, completed 12/15/22, indicated she had moderate cognitive impairment. A care plan, last revised on 12/20/22, indicated that Resident C utilized nicotine products. The goal was for her to be able to articulate the risks of continued cigarette use. The approaches	F 0926	1. No residents were harmed by this deficient practice. 2. All smokers have the potential to be affected. DON/Designee will complete smoking assessments on all smokers to validate all supervised and unsupervised smokers, and any interventions required for supervised smokers. 3. Residents will be educated on smoking policy regarding sharing cigarettes, the door out to the courtyard has been repaired, no smoking signs have been posted, and ash trays removed from ambulance entrance, staff educated regarding supervised smoking and interventions for supervised smokers, ash trays have been removed and replaced with free standing ash urns. Facility to store resident cigarettes in central locked location. Smoking monitor to be hired to supervise smokers and smoking materials. Job posted as of March 6. **4.** 4. The following audits and/or observations will be conducted by ED/designee; an audit of the ambulance entrance area for smoking; an audit of the courtyard for cigarette butts; an audit of supervised smokers ensuring	03/20/2023

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	included, but were not limited to, educate her to the facility smoking policy, initiated 10/27/22. On 2/15/23 at 11:15 a.m., Resident C was observed in the designated smoking area with multiple other residents. There were no facility staff present in the designated smoking area. Resident B was observed being offered a half smoked, lit cigarette by another resident. Resident B took the cigarette from the other resident, placed to her mouth, and finished smoking it. 2. The clinical record for Resident D was reviewed on 2/15/23 at 11: 20 a.m. The Resident's diagnosis included. but were not limited to, nicotine dependence and heart failure. A care plan, last revised on 5/27/22, indicated Resident D utilized nicotine products. The goals were for her to be safe while smoking independently, last revised on 2/3/23, and that she would be able to articulate the risks of cigarette use. The interventions were to complete smoking evaluation and educate her on designated smoking areas and side effects of extended nicotine use. A Smoking Assessment, dated 10/2/22, indicated Resident D used cigarettes and that she smoked between 3 and 5 times daily. She was able to light her own cigarette and to dispose of cigarettes appropriately. She was independent with smoking. A Quarterly MDS Assessment, completed on 11/26/22, indicated she was cognitively intact. On 2/15/23 at 11:20 a.m., Resident D was observed in the designated smoking area. She had finished smoking a cigarette and was attempting to re-enter		safety interventions are in place; an audit of the door to courtyard to ensure functionality, 5x's per week for 30 days, then 3 times per week for 30 days, and 10 times per month for 4 months. Facility to bring results to QAPI for 6 months, or until 100% compliance is achieved.	

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	the building. She had her pack of cigarettes in her hand. There were no staff members present in the designated smoking area. Resident D asked the other residents in the smoking area if someone would hold the doors for her so that she could get back into the building. 3. The clinical record for Resident E was reviewed on 2/15/23 at 12:44 p.m. The Resident's diagnosis included, but were not limited to, spinal stenosis and depression. A care plan, last revised on 5/27/22, indicated Resident E utilized nicotine products and was an independent smoker. The goal was for her to remain safe while smoking. The interventions included, but were not limited to, smoking evaluations to be completed as scheduled, revised on 5/27/22. An Annual MDS Assessment, completed 11/18/22, indicated she was cognitively intact. A Smoking Assessment, dated 11/24/22, indicated Resident E used cigarettes and that she smoked between 3 and 5 times daily. She was able to light her own cigarette and to dispose of cigarettes appropriately. She was independent with smoking. A physician's order, dated 1/4/23, indicated she was to use oxygen at 4 litter/minute each shift continuously. On 2/15/23 at 12:44 p.m., Resident F was observed sitting on a patio by the ambulance entrance of the facility. She was sitting close to the entrance door to the facility and talking with another resident who smoking a cigarette and sitting by			

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	the round metal table on the patio, approximately 6 to 8 feet from the entrance door. Resident C had her oxygen on and a portable oxygen tank hanging from the back of her wheelchair. She was holding a fast-food bag on her lap. The entrance door was opened by an employee and Resident F entered the building. During an interview on 2/15/23 at 12:50 p.m., the ED (Executive Director) indicated that the patio by the ambulance entrance was not a designated smoking area, however, some of the residents would smoke there if they were waiting for transportation. 4. The clinical record for Resident F was reviewed on 2/14/23 at 11:51 a.m. The Resident's diagnosis included, but were not limited to, diabetes and history of stroke. A care plan, last revised on 3/29/22, indicated Resident F was a smoker and prefers to wear a smiling apron while smoking. The goal was for her to be able to articulate the risks of continued cigarette use. The interventions included, but were not limited to, educate her on the designated smoking area and the facility smoking policy, initiated 3/29/22, and provide safe smoking devices such as smoke apron, initiated 3/29/22. A Quarterly MDS Assessment, completed 12/8/22, indicated she was cognitively intact. A Smoking Assessment, dated 12/12/22, indicated Resident F used cigarettes and that she smoked between 6 and 10 times daily. She was able to light her own cigarettes and needed adaptive equipment of a smoking apron. She had tremors that could impact her ability to manage her own nicotine use and could not dispose of her			

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	cigarette appropriately On 2/15/23 at 1:25 p.m., Resident F was observed sitting in the designated smoking area. She was talking with another resident and asked him to get her cigarettes for her out of her dresser drawer. The other resident went inside of the building and came back to the designated smoking area with Resident F's cigarettes. He assisted her with opening the pack and got a cigarette out for her and then lit it for her. She was not wearing a smoking apron and there were not staff members present in the smoking area when her cigarette was lit. On 2/15/23 at 1:45 p.m., LPN (Licensed Practical Nurse) 6 indicated that she was unaware that Resident D or E were smokers. She had never given them their cigarettes or kept any for them at the nurses' station. On 2/15/23 at 2:00 p.m., the designated smoking area was observed with the DM (Director of Maintenance). The gazebo in the smoking area had an ashtray which had a lid that did not close. The DM indicated that it was a safety ashtray, which would allow the cigarette buts to fall into the ashtray and the lid should then automatically close after the but falls in. The lid to the ashtray needed replaced because it was broken. He was unaware how often the covered metal outdoor ashtray was emptied. There were 3 open round ashtrays sitting on milk cartoons in different parts of the designated smoking area. The ground at the end of the cement patio was littered with more than 30 cigarette buts. The DM indicated that the round ashtrays needed to have new safety lids, as the old lids must have broken and that the ground around the area was cleared of cigarette buts daily. He was unsure if it had already been done.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155334	A. BUILDING 00 B. WING	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	On 2/15/23 at 2:25 p.m., the MD, ED, MA (Maintenance Assistant) were interviewed. The MA indicated he had cleaned the cigarette buts from the ground that morning and routinely cleaned up the cigarette buts from the ground in the smoking area on Mondays, Tuesdays, Wednesdays, and Fridays. The cigarette buts on the ground accumulated very quickly. The DM indicated that it was an ongoing problem. The ED indicated that the residents did not use the ashtrays as they should. On 2/15/23 at 1:05 p.m., the DNS (Director of Nursing Services) provided the Resident/Patient Smoking policy, last revised 9/20/22, which read "...Definitions...Smoking Apron: a fire-resistant apron used to cover the torso or body and lap to aid in preventing cigarette ashes or dropped cigarettes from igniting clothing. Smoking Materials: Smoking materials include but are not limited to cigarettes, cigars, electronic cigarettes... lighters and matches...Independent Smoker: a resident that is able to demonstrate safe smoking habits including smoking materials management, lighting, controlling cigarette ash and extinguishing smoking materials...Supervised Smoker: A resident that is unable to demonstrate safe smoking habits including smoking materials management, lighting, controlling cigarette ash and extinguishing smoking materials and requires staff supervision when smoking...Procedure...2. Assessment for independent or supervised smoking determination is performed by the IDT [sic] team that includes but is not limited to direct observations of smoking performance to assess for: a. Level of Cognition for safe smoking b. Level of dexterity to manage smoking and smoking materials c. Assessment of ability to			

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	understand and comply with policy d. Assessment of ability to smoke safely...5. Smokers will be permitted to smoke only in designated smoking areas a. For supervised Smokers: smoking times will be posted by the facility 7. Sharing, bartering, or selling of smoking materials with others, including other resident, is not permitted...8. Facility staff will: a. Secure smoking materials in a locked area when not in use by the resident...for both independent and supervised smokers...9...b. Smoking will only be in designated area...10. Safe designated smoking area[s] will include access to...c. Appropriate safety ashtrays...Safety features such as non-combustible materials, heavy to avoid tipping..." This Federal tag relates to Complaint IN00401802.			