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	09/27/2023

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/27/23 Facility Number: 000227 Provider Number: 155334 AIM Number: 100267520 At this Emergency Preparedness survey, Wildwood Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 160 certified beds. At the time of the survey, the census was 142. Quality Review completed on 10/03/23	E 0000	On September 27, 2023 an annual Life Safety recertification survey from ISDH was completed at Wildwood Healthcare. Enclosed please find the stated list of the deficiency with the facility's plan of correction for this alleged deficiency. 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 October 27, 2023 Respectfully Ethan Peak, Executive Director	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/27/23 Facility Number: 000227 Provider Number: 155334	K 0000	On September 27, 2023 an annual Life Safety recertification survey from ISDH was completed at Wildwood Healthcare. Enclosed please find the stated list of the deficiency with the facility's plan of correction for this alleged deficiency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ethan	Peak	10/13/2023

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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	AIM Number: 100267520 At this Life Safety Code survey, Wildwood Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in Resident Rooms 1 through 12 and 700 through 715. The facility has battery operated smoke detectors installed in all other resident sleeping rooms. The facility has a capacity of 160 and had a census of 142 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has no detached buildings providing other facility services. Quality Review completed on 10/03/23		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 October 27, 2023 Respectfully Ethan Peak, Executive Director	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5			

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	Based on observation and interview, the facility failed to meet clear width requirement exceptions per LSC 19.2.3.4(1) for 1 of 6 corridors. LSC 19.2.3.4(1) requires aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall not be less than 44 inches in clear and unobstructed width. This deficient practice could affect staff only. This deficient practice could affect as many as 6 staff in the kitchen. Findings include: Based on observations made with the Maintenance Supervisor during a tour the facility on 09/27/23 at 2:15 p.m., the "tray return hall" located between the dining room and the kitchen was totally obstructed by two large yellow 55-gallon trash containers. These two containers obstructed the corridor leaving no way to use it in case of a fire or emergency. Based on an interview with the Maintenance Supervisor at the time of the observation, he stated that residents and staff use the containers to discard trash and uneaten food before placing the dishes and utensils onto the conveyor for cleaning and confirmed that the egress corridor was completely blocked and would be difficult to use in the event of an emergency. This item was again discussed at the exit conference with the Maintenance Supervisor on 09/27/23 at 3:26 p.m. 3.1-19(b)	K 0232	1 No residents here harmed by deficient practice. Barrels were moved when not in use. 2 All residents have potential to be affected. Barrels to be moved into kitchen when not in use. 3 Staff educated on procedure to only keep barrels there when cleaning carts out, and place in kitchen when not in use to not obstruct hallway. 4 An audit of cart placement will be conducted by dietary manager or designee 3x's daily after each meal, 5 times per week times 4 weeks. Then 3x's daily after meals 3 times per week for 4 weeks, then twice per day after meals 3 times per week for 4 weeks, then twice a week for 3 months. Documented results will be brought to QAPI for 6 months, or until 100% compliance has been achieved.	10/27/2023
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire			

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	barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 14 hazardous areas such as a soiled linen rooms or hazardous areas greater than 50 square feet was separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice could affect 35 residents, 6 staff, and 2 visitors.	K 0321	1 No residents were harmed by deficient practice. Door stop was immediately removed and discarded. 2 All residents have potential to be affected by deficient practice. A facility tour was completed to ensure no other doors were propped open-	10/27/2023

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	Findings include: Based on observations made with the Maintenance Supervisor during a tour the facility on 09/27/23 at 1:50 p.m., the corridor door to the Environmental Services office was equipped with a self-closing device but the door was being held in the open position by a door wedge. This room was approximately 200 square feet in size and contained numerous boxes of paper towels, cleaning chemicals, and hazardous materials creating a hazardous environment. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the corridor door to the aforementioned hazardous area was being held open by a door wedge. This item was again discussed at the exit conference with the Maintenance Supervisor on 09/27/23 at 3:26 p.m. 3.1-19(b)		identified concerns were addressed immediately. 3 Staff educated on ensure doors are not propped open A facility round will be completed to ensure doors are not propped open, rounds will be completed 5x's per week by Maintenance or designee x 4 weeks, then twice a week x 4 weeks, then twice a month x 4 months. Documented results will be brought to QAPI for 6 months, or until 100% compliance has been achieved	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____			

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	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 10 sprinkler system gauges were kept in good working condition. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.2 states gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations made with the Maintenance Supervisor during a tour the facility on 09/27/23 at 1:10 p.m., the riser room for the sprinkler system had a total of ten gauges. One of the gauges showed 0 p.s.i. or holding no pressure. The fire alarm control panel was then checked, but there was no supervisory or trouble alarm noted. Based on interview at the time of the observations, the Maintenance Supervisor stated he had visually checked all the gauges on 09/25/23 as was noted in his control valve and gauge inspection form, so the gauge must have just recently failed within the last 48 hours adding that he would have his vendor out to replace the gauge as soon as possible. This item was again discussed at the exit conference with the Maintenance Supervisor on 09/27/23 at 3:26 p.m. 3.1-19(b)	K 0353	1 No residents were harmed by this deficient practice. A call was placed to Safecare for a quote to replace gauge. 2 All residents have the potential to be affected. An initial audit of all gauges in riser room was completed to ensure system is functioning properly. 3 Maintenance educated on ensuring sprinkler system/fire panel is in good working order. Safecare to come replace gauge. 4 An audit will be completed to ensure gauges are in good working order, audit will be completed by maintenance or designee 5x's per week for 4 weeks, then 2 times per week for 4 weeks, then once a week for 4 weeks, and then twice a month for 3 months. Results of audits will be brought to QAPI for 6 months or until 100% compliance is achieved.	10/27/2023

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K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect approximately 60 residents, 8 staff and 3 visitors. Findings include: Based on observations made with the Maintenance Supervisor during a tour the facility on 09/27/23 at 1:52 p.m., the set of smoke barrier doors nearest to resident room #100 did not close. There was a two-inch gap between the doors when closed to their fullest and the doors were tested three times. Based on interview during the time of observations, the Maintenance Supervisor acknowledged these smoke barrier doors did not	K 0374	1 No residents were harmed by this deficient practice. The smoke barrier door was adjusted to ensure it closes properly. 2 A facility tour was completed to ensure all other smoke barrier doors are able to close without obstruction or gaps. Any other identified concerns will be addressed by maintenance. 3 Maintenance was educated on ensuring smoke barrier doors close properly. This set of doors was fixed and ensured it closes properly. 4 An audit of smoke barrier doors will be conducted by maintenance or designee to ensure all smoke barrier doors close properly with no gaps or obstructions. The audit will be conducted daily 5x's per week for	10/27/2023

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	close completely adding that he would work on them as soon as he had the time to do so. This item was again discussed at the exit conference with the Maintenance Supervisor on 09/27/23 at 3:26 p.m. 3.1-19(b)		4 weeks, then 2 times per week for 4 weeks, the twice a month for 4 months. Results of audit will be brought to QAPI for 6 months or until 100% compliance is achieved.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure 3 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review of the facilities fire drill documentation entitled "Direct Supply - TELS"	K 0712	1 No residents were harmed by this deficient practice. Verification will be provided for all fire drills regarding transmission. 2 All residents have the potential to be affected by this deficient practice. Maintenance director will call Safecare to check any transmission notifications for identified dates that were missed in the past. 3 Maintenance educated on documentation for fire drills regarding transmission to monitoring company. 4 An audit of documentation	10/27/2023

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	with the Maintenance Supervisor on 09/27/23 at 11:40 a.m. the following was noted: a) the fire drill conducted on 01/09/23 at 1:15 p.m. did not verify the transmission of the fire alarm signal with the monitoring company. b) the fire drill conducted on 06/27/23 at 4:35 a.m. did not verify the transmission of the fire alarm signal with the monitoring company. c) the fire drill conducted on 12/27/22 at 2:30 a.m. did not verify the transmission of the fire alarm signal with the monitoring company. Based on interview at the time of record review, the Maintenance Supervisor indicated that he must have forgotten to document the times on his forms. This item was again discussed at the exit conference with the Maintenance Supervisor on 09/27/23 at 3:26 p.m. 3.1-19(b) 3.1-51(c)		for fire drills will be completed by ED or designee. Audit will be completed 1x/ month for 6 months following each fire drill for verification of transmission of fire alarm signal to monitoring company. Audit results will be brought to QAPI for 6 months or until 100% compliance has been achieved.	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less			

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	than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure trash and dirty linen receptacles in the corridors were maintained in accordance with 19.7.5.7. This deficient practice could affect approximately 60 residents, 8 staff and 3 visitors. Findings include: Based on observations made with the Maintenance Supervisor on 09/27/23 between 1:10 p.m. to 3:16 p.m. during a tour the facility, the following was noticed: d) there was a 55-gallon trash container in the 200 hall outside resident room #204. e) there was a 55-gallon trash container in the 300 hall outside resident room #306. f) there was a 55-gallon trash container in the 500 hall outside resident room #505. Based on interview with the Maintenance Supervisor at the time of the observation, he acknowledged the trash container in the corridor and added that he has found these items in the corridor before and that he has mentioned it to nursing staff, but they still use the area for storage. This item was again discussed at the exit conference with the Maintenance Supervisor on 09/27/23 at 3:26 p.m. 3.1-19(b)	K 0754	1 No residents were harmed by this deficient practice. 2 All residents have the potential to be affected by this deficient practice. Barrels were removed from the hallways immediately and placed in soiled utility rooms. 3 Staff to be educated on proper storage of barrels of this size and not leaving them in the hallway. 4 A facility round will be completed to ensure barrels are not left in hallways, rounds will be completed 5x's per week by Maintenance or designee x 4 weeks, then twice a week x 4 weeks, then twice a month x 4 months. Documented results will be brought to QAPI for 6 months, or until 100% compliance has been achieved.	10/27/2023