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	11/27/2024

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: 11/27/24 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 139. Quality Review completed on 12/03/24	E 0000	On November 27, 2024 an annual Life Safety 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 December 20 2024. 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: 11/27/24 Facility Number: 000227 Provider Number: 155334	K 0000	On November 27, 2024 an annual Life Safety 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	Executive Director	12/13/2024

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 001 through 012 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 139 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has no detached buildings providing facility services. Quality Review completed on 12/03/24		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 December 20 2024. Respectfully Ethan Peak, Executive Director	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors 1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 12 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC	K 0222	1 No residents were harmed by deficient practice. Code was placed by keypad for ability to unlock door. Egress stickers were placed on both doors in therapy room. 2 Over 20 residents had the potential to be affected, code was	12/20/2024

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	19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 11:20 a.m. to 1:50 p.m. on 11/27/24, the exit door to the outside of the facility by the sprinkler riser room was marked as a facility exit with an exit sign. The exit door was magnetically locked and could be unlocked by entering a code at a keypad by the door to release the door to open. The code to release the door to open was not posted at the keypad. Based on interview at the time of the observations, the Director of Maintenance agreed the code to release the door to open was not posted at the keypad. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 11 delayed egress locks were readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with		placed by keypad for ability to unlock the door. Egress stickers were placed on both doors in therapy room. 3 Maintenance staff educated on need to have codes posted for doors that do not release with 15 second delay, and signage posted on doors with delayed egress. 4 An audit will be conducted by maintenance director or designee to ensure codes are posted and/or the door releases with the 15 sec and stickers remain on therapy exit doors. Audit will be 5x/s per week for 4 weeks, then 3 x's per week for 4 weeks, then weekly for 8 weeks. Documented results will be brought to QAPI for review for 6 months or until 100% compliance has been achieved.	

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	Section 9.7, and where permitted in Chapters 12 through 42, provided: (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect over 5 residents, staff and visitors if needing to exit the facility from the west Therapy Room. Findings include: Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 11:20 a.m. to 1:50 p.m. on			

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	11/27/24, the exit door to the outside of the facility in the west Therapy Room was marked as a facility exit with an exit sign. The exit door was not marked with delayed egress signage but the door released to open when pushed for 15 seconds multiple times. Based on interview at the time of the observations, the Director of Maintenance agreed the west Therapy Room exit door was not marked with the necessary delayed egress signage. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)			
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Based on observation and interview, the facility failed to meet the clear width requirement for 1 of 14 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet.	K 0232	1 No residents were harmed by the deficient practice. Table and chairs removed from hallway. 2 Over 20 residents have the potential to be affected by this deficient practice. Table and chairs were removed from the hallway. 3 Maintenance staff, receptionist and unit staff educated on leaving furniture in the hallway that is not fixed to the floor or wall. 4 An audit will be conducted by maintenance director or designee to ensure furniture is removed from hallway, while not in use. This audit will be conducted 5x's per week for 4 weeks, then 3 x's per week for 4 weeks, then 2	12/20/2024

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	(f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility using the west exit door by the oxygen storage and transfilling room. Findings include: Based on observations at the entrance to the facility at 8:45 a.m. on 11/27/24, two chairs and a table were stored in the corridor outside the west oxygen storage and transfilling room near the west exit door for the facility. The table and chairs were to be used as a sign in area for visitors when the main entrance lobby was not open. Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 11:20 a.m. to 1:50 p.m. on 11/27/24, the two chairs and the table were still stored in the corridor near the west exit door. The two chairs were stored on one side of the corridor up against the corridor wall and projected 32 inches into the eight foot wide corridor. The table was stored next to the chairs and projected eight inches into the eight foot wide corridor. The two chairs and the table were not affixed to the floor or to the wall. Based on interview at the time of the observations, the Director of Maintenance agreed		x's per week for 4 weeks and then once per week for 3 months. Documented results of the audit will be brought to QAPI for 6 months, or until 100% compliance has been achieved.	

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	the furniture stored in the corridor near the west exit of the facility was not affixed to the floor or to the wall and the chairs reduced the clear unobstructed corridor width to less than the required six feet. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)			
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Based on record review, observation and interview; the facility failed to document annual testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect over 5 residents, staff and visitors in the dialysis room.	K 0291	1 No residents were harmed by the deficient practice. A 90 minute test was conducted and documented. 2 Over 5 residents have the potential to be affected by this deficient practice. A 90 minute test was conducted and documented. 3 Maintenance staff was educated on the requirements to have emergency lighting tested per regulation, including 90 minute tests annually. An audit will be conducted to ensure all emergency lighting has met requirement for the 90 minute annual test. This audit will be conducted by the Maintenance director and signed off by the Executive Director and Maintenance Director to ensure documentation compliance. Results will be brought to QAPI for 6 months or until 100%	12/20/2024

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	Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Lighting: Conduct a 90 minute operational test annually" documentation with the Executive Director and the Director of Maintenance during record review from 8:50 a.m. to 11:20 a.m. on 11/27/24, annual 90-minute battery operated light testing documentation for the most recent twelve month period for the "dialysis Unit" location was not available for review. The "dialysis unit" location light was included on monthly thirty second functional testing documentation for the most recent twelve month period but the "dialysis unit" light location was not included on annual 90-minute testing documentation. Based on interview at the time of record review, the Director of Maintenance stated he needed to update the 90-minute testing documentation to include the "dialysis unit" battery light location and agreed annual 90-minute battery light testing documentation for the most recent twelve month period for the "dialysis unit" light location was not available for review. Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 11:20 a.m. to 1:50 p.m. on 11/27/24, one battery operated light location was noted in the dialysis room which illuminated when its respective test button was pushed. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)		compliance has been achieved.	

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 2 of over 23 hazardous areas such as Laundries (larger than 100 square feet in size) and fuel-fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 11:20 a.m. to 1:50 p.m. on 11/27/24, the corridor door to the soiled linen side of the East Laundry Room was equipped with a self-closing device and latching hardware to latch the door into the door frame but the door failed to fully self-close and latch into the door frame when tested to close multiple times. In addition, the corridor door to the Mechanical Room by Room 003 was also equipped with a self-closing device and latching hardware to latch the door into the door frame but the door failed to fully self-close and latch into the door frame when tested to close multiple times. The Mechanical Room by Room 003 contained one natural gas fired water heater. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned two hazardous areas were not separated from other spaces by smoke resistant partitions and doors with the doors not fully self-closing and latching into the door frame. These findings were reviewed with the Executive Director and the Director of Maintenance during	K 0321	1 No residents were harmed by deficient practice. Laundry room and Mechanical room doors were adjusted to ensure they latched and fully self-closed 2 Over 20 residents have the potential to be affected by this deficient practice. Laundry room and Mechanical room doors were adjusted to ensure they latched and fully self-closed. 3 Maintenance staff educated on the requirement for doors to self closing and fully latch. 4 An audit will be conducted to ensure the Laundry room door and mechanical room by 003 are able to self close at latch. The audit will be conducted by the Maintenance director or designee, will be conducted 5x's per week for 4 weeks, then 3x's per week for 4 weeks, the once per week for 4 weeks, and twice per month for 3 months. Documented results will be brought to QAPI for 6 months or until 100% compliance has been achieved.	12/20/2024

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	the exit conference. 3.1-19(b)			
K 0521 SS=F Bldg. 01	NFPA 101 HVAC Based on observation and interview, the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance within the most recent four year period in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states that each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every 4 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. Section 19.4.3 states that full unobstructed access to the fire damper shall be verified and corrected as required. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0521	1 No residents were harmed by deficient practice. Inspection company was called and asked to come inspect and validate fire damper safety. 2 All residents have the potential to be affected by the deficient practice. Inspection company was called and asked to come inspect and validate fire damper safety. 3 Maintenance Director was educated on ensuring all fire dampers are listed and documented for inspection every 4 years. 4 An audit by Maintenance Director or designee will be completed of fire damper twice per month for 2 months, to ensure stickers are visible and present. Then once a month for 4 months. Results of audit will be brought to QAPI for 6 months or until 100% compliance has been achieved.	12/20/2024

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	Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 11:20 a.m. to 1:50 p.m. on 11/27/24, the fire damper inspection contractor had affixed inspection stickers to fire damper locations throughout the building except at one of three fire damper locations inside the main electrical room behind the kitchen. Each inspection sticker throughout the facility indicated the inspection contractor performed four year interval inspection and testing on 10/16/23 but the wall mounted fire damper location in HVAC ductwork above the electrical panels in the main electrical room was not equipped with an inspection sticker indicating the necessary maintenance was performed within the most recent four year period for that fire damper location. Based on interview at the time of the observations, the Director of Maintenance agreed it could not be ensured the aforementioned fire damper location was inspected and tested within the most recent four year period. This finding was reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b)			
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include:	K 0712	1 No residents were harmed by deficient practice. A third shift fire drill was conducted December 5, 2024 at 1235am. 2 All residents have potential to be affected. A third shift fire drill was conducted December 5, 2024 at 1235am.	12/20/2024

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	Based on review of Direct Supply TELS Logbook Documentation "Fire Drills" documentation with the Executive Director and the Director of Maintenance during record review from 8:50 a.m. to 11:20 a.m. on 11/27/24, third shift fire drills conducted within the most recent twelve month period on 12/02/23, 06/22/24 and 09/14/24 were conducted at, respectively, 5:15 a.m., 6:00 a.m. and 5:15 a.m. Based on interview at the time of record review, the Director of Maintenance stated the facility operates three shifts per day, additional third shift fire drill documentation was not available for review and agreed the aforementioned third shift fire drills were not conducted at unexpected times under varying conditions. These findings were reviewed with the Executive Director and the Director of Maintenance during the exit conference. 3.1-19(b) 3.1-51(c)		3 Maintenance Director was educated on requirement for varying, unexpected times of fire drills. 4 An audit will be conducted by executive director to ensure varying times of quarterly fire drills. This audit will be conducted once per month for 6 months to validate varying times per requirement. Results of the audit will be brought to QAPI for 6 months or until 100% compliance has been achieved.	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved	K 0920	1 No residents were harmed by the deficient practice. Residents powerchair charger was removed from power strip and plugged into the wall. 2 2 residents have the potential to be affected. The residents powerchair charfer was removed from the power strip and plugged into the wall. 3 Staff are educated on proper use of power strips to ensure no medical equipment is to be	12/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155334	A. BUILDING 01 B. WING	11/27/2024

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

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	in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 2 residents, staff and visitors in resident sleeping Room 006. Findings include: Based on observations with the Executive Director and the Director of Maintenance during a tour of the facility from 11:20 a.m. to 1:50 p.m. on 11/27/24, an operating fan, two cell phone charging cables and a battery charger for a powered wheelchair were plugged into a power strip placed on the floor under the resident bed nearest the window in resident sleeping Room 006. The UL listing of the power strip was 1363A. Based on interview at the time of the observations, the Director of Maintenance agreed that a power strip was being used in the patient care vicinity for PCREE and non-PCREE and was also being used as a substitute for fixed wiring in the aforementioned resident sleeping room. These findings were reviewed with the Executive Director and the Director of Maintenance during		plugged into power strips. 4 An audit will be conducted to ensure power strips are used properly by requirement, the audit by Maintenance Director or designee will be conducted 2x/s per week for 8 weeks, then once per week for 4 weeks, then 2 times per month 3 months. Results of the audit will be brought to QAPI for 6 months, or until 100% compliance has been achieved.	

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	the exit conference. 3.1-19(b)			