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	04/16/2025

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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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00455835, IN00457238, IN00457346, and IN00457650. Complaint IN00455835 - No deficiencies related to the allegations are cited. Complaint IN00457238 - Federal/State deficiencies related to the allegations are cited at F554. Complaint IN00457346 - No deficiencies related to the allegations are cited. Complaint IN00457650 - Federal/State deficiencies related to the allegations are cited at F600. Survey dates: April 15 and 16, 2025 Facility number: 000227 Provider number: 155334 AIM number: 100267520 Census Bed Type: SNF/NF: 139 Total: 139 Census Payor Type: Medicare: 3 Medicaid: 115 Other: 21 Total: 139 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 23, 2025.	F 0000	On April 16th complaint surveyors 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 May 14th, 2025 Respectfully,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ethan Peak	Executive Director	05/03/2025

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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F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on interview and record review, the facility failed to ensure a resident was administered medications per their policy for 1 of 3 residents reviewed for medication compliance. (Resident B) Findings include: The clinical record for Resident B was reviewed on 4/15/2025 at 1:35 p.m. The medical diagnoses included stroke and heart failure. A Quarterly Minimum Data Set Assessment, dated 2/6/2025, indicated Resident B had moderate cognitive impairment. A heart failure care plan, revised 9/18/2024, indicated Resident B was at risk for complications related to heart failure, and an intervention of administering medications as ordered. During an interview on 4/15/2025 at 1:15 p.m., Resident B indicated a few weeks ago a nurse came into his room and gave him medications which were not his. She put the medications on his bedside table and left. When she was gone, he got out of bed and took the medications up to the night shift supervisor but could not recall her name. The night shift supervisor told him the medications were not his and disposed of them. During an interview on 4/15/2025 at 1:58 p.m., Licensed Practical Nurse (LPN) 2 indicated she worked with Resident B regularly. Resident B does not have a history of making false allegations to her knowledge and the staff were to administer his medications to him, including	F 0554	1 Resident B was not harmed by the deficient practice and has since discharged the facility. 2 All residents have the potential to be affected. An audit was conducted on all residents to ensure no medications were left with resident without supervision if the resident does not have orders, preference, and care plan to self-administer medications. 3 LPN 4 has not worked at facility since incident. All licensed nurses and medication aides were educated on facility policy "Medication Administration" with an emphasis on not leaving medications with residents unattended. 4 Director of nursing or designee will round resident rooms 7 days per week x 4 weeks to ensure no medications are left with residents unattended, then 5 days per week x 4 weeks, then 3 days per week x 12 weeks. Results of the audit will be brought to QAPI for 6 months or until 100% compliance has been achieved.	05/14/2025

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	watching Resident B consume the medications. During an interview on 4/15/2025 at 2:15 p.m., the Director of Nursing (DON) indicated she was aware of a concern about potential medication compliance issues regarding Resident B. The last weekend of March, Resident B brought a cup for a medications to the nurse's station, and gave them to LPN 3. The medications were believed to be prepared by LPN 4, who was not present when Resident B provided the medications to LPN 3. It was determined there was one additional medication in the cup provided, but the facility determined no medication error had happened due to Resident B not consuming the incorrect medication. During an interview on 4/16/2025 at 1:55 p.m., the DON indicated Resident B does not self-administer medications and it was the expectation of the facility that staff should have stayed with Resident B until he takes his medications. A policy entitled "Medication Administration" was provided by the Executive Director on 4/16/2025 at 11:00 a.m. The policy indicated, " ... Licensed or authorized personnel may administer prescribed medications ..." which included to, " ...Never leave medications unattended ..." This citation relates to Complaint IN00457238. 3.1-11(a)			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect Based on observation, interview, and record review, the facility failed to ensure a resident was	F 0600	1 Resident D was not harmed by the deficient practice and	05/14/2025

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	free from verbal abuse by staff for 1 of 3 residents reviewed for abuse. (Resident D) Findings include: The clinical record for Resident D was reviewed on 4/16/25 at 10:00 a.m. Her diagnoses included, but were not limited to, bipolar disorder, anxiety, depression, and attention deficit disorder. The 2/12/25 Significant Change MDS (Minimum Data Set) Assessment indicated she was cognitively intact. She required partial/moderate assistance for upper body dressing, substantial/maximal assistance for lower body dressing, putting on and taking off footwear, and transferring from the chair to bed. The behavior care plan for Resident D, revised 3/30/25, indicated she had a behavior problem and refused to be checked and changed at times. Resident D and her spouse would panhandle off property at times, would hoard items, refused medications at times, made false statements/allegations, and sought male attention. Interventions included to approach and speak in a calm manner and to honor resident's preferred choices. An interview was conducted with Resident D in her room on 4/16/25 at 10:08 a.m. Resident D was lying in bed at this time. Her roommate, Resident Z, was not present in the room during this interview. Resident D indicated Certified Nurse Aide (CNA) 7 called her a b**** the previous day, prior to going out for an appointment. This started when CNA 7 came into her room to see if she was done eating breakfast. Resident D requested CNA 7 move her bedside table. Resident D first yelled at CNA 7 and called CNA 7		remains at her psychosocial baseline. 2 All residents have the potential to be affected by the deficient practice. Interviews were conducted on interviewable residents to identify any further issues. 3 Staff were educated on facility policy “Abuse & Neglect & Misappropriation of Property” with an emphasis on verbal abuse. 4 Social services or designee will interview 10 residents weekly x 4 weeks to identify if any verbal abuse has occurred, then 5 residents weekly x 4 weeks, then 3 residents weekly x 12 weeks, . Results of the audit will be brought to QAPI for 6 months or until 100% compliance has been achieved.	

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	a b****. Then CNA 7 stated to her, "I got your b****, b****." Resident D reported this to UM (Unit Manager) 8. UM 8 informed Resident D that she would handle it. Resident D informed UM 8 that she did not want CNA 7 in her room anymore. No one came to speak with Resident D about the incident before right now. An interview was conducted with UM 8 in her office on 4/16/25 at 10:15 a.m. She indicated she spoke with Resident D several times yesterday. There was a CNA (CNA 7) who went into Resident D's room yesterday, but Resident D did not inform UM 8 that the CNA was rude, just that Resident D did not like the CNA. UM 8 switched assignments for CNA 7, so that she did not provide care for Resident D. UM 8 was unsure who the CNA was at this time, as she could not remember her name. Resident D did not inform UM 8 as to why Resident D did not like the CNA. Resident D did not report to UM 8 that the CNA cursed at her. UM 8 spoke with the CNA about it, and the CNA informed UM 8 that Resident D yelled at her, so CNA 7 told Resident D that wasn't nice and left the room. An interview was conducted with the Executive Director (ED) and DON (Director of Nursing) on 4/16/25 at 10:20 a.m. After being informed of Resident D's allegation of verbal abuse against CNA 7, he indicated this was the first time hearing of it. He was going to report it and start an investigation. An interview was conducted with CNA 7 on 4/16/25 at 10:40 a.m. She indicated she only cared for Resident Z the previous day, because Resident D refused care. CNA 7 never worked that particular unit before yesterday. CNA 7 was "back and forth" into their room two to three times,			

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	because they both had doctor appointments to go to that day. Resident D wanted to get up around 12:45 p.m., but her appointment was around that time, and lunch trays also needed passed around that time. CNA 7 went into their room every thirty minutes to prompt them to get up. The last time she went into the room was around 11:45 a.m., when Resident D informed her, she did not want her in the room and was tired of her waking her up. "I said fine. You don't have to," so she left and got UM 8. Resident D was telling CNA 7 she was getting on her nerves, calling her a b****, saying get out of here, and don't come back, and I'm sick of you. CNA 7 thought perhaps Resident D had her confused, because she'd never cared for Resident D before. Resident Z was present in the room "while all this was going on." UM 8 heard the yelling and came into the room as CNA 7 was exiting. The other nurse, LPN 9, came in too. LPN 9 finished up care with Resident D and told CNA 7 to leave the room. "I was told I needed to switch another aide for a resident." This was the first time she ever cared for Resident D. "I think she got my face mixed up with someone else. I did not call her a b**** back. Her roommate (Resident Z) was there, so she would know how I responded." The 2/11/25 Quarterly MDS Assessment indicated Resident Z was cognitively intact, her hearing was adequate with no hearing aid or hearing appliance, and her ability to understand others was understood, with clear comprehension. The 3/31/25 behavior care plan indicated Resident Z had sexually inappropriate behaviors, refusal of care/showers, yelled at staff, hoarded, and kept room messy/cluttered. The care plan did not reflect a history of false allegations.			

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	An interview was conducted with SSD (Social Services Director) 10 on 4/16/25 at 10:54 a.m. She indicated Resident Z had been at the facility for at least six months, and SSD 10 was pretty familiar with Resident Z. SSD 10 didn't think Resident Z had any behaviors or a history of making false allegations that she was aware of but needed to look at her care plans. After reviewing Resident Z's care plans, SSD 10 indicated she saw a behavior care plan for Resident Z regarding sexually inappropriate behaviors, but nothing about a history of false allegations. If SSD 10 were aware of a resident having a history of false allegations, or if staff made her aware of it, she would make a care plan to address it. If Resident Z told her something, she would tend to believe it, as Resident Z had "never given me a reason not to believe her." An interview was conducted with Resident Z, Resident D's roommate, on 4/16/25 at 10:36 a.m. in the outside smoking area of the facility by herself. Resident D was not present in the smoking area during this interview. She indicated she'd definitely witnessed verbal abuse in the facility. Her roommate, Resident D, "jumps on" staff when they try to do their job. Yesterday morning, Resident Z woke up to CNA 7 and Resident D yelling. Resident D called CNA 7 a b****. CNA 7 called Resident D a b**** back, saying to Resident D that, "You can't just be in here calling people b****** that take care of you." Resident Z did not see anything wrong with what CNA 7 said to Resident D, because CNA 7 was right about not being able to talk to the people who take care of you like that. Resident Z heard the whole thing, which could also be heard at the nurses station, because LPN (Licensed Practical Nurse) 9 and UM 8 came to the room. No one had asked Resident Z about this incident prior to right			

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	now. CNA 7 cared for Resident Z later in the day, but not Resident D. An interview was conducted with Licensed Practical Nurse (LPN) 9 on 4/16/25 at 11:45 a.m. She indicated she went into Resident D's and Z's room yesterday close to their appointment times, as they were hard to get up sometimes. When LPN 9 entered the room, the only people in the room were Resident D, Resident Z, and CNA 7. Resident Z and CNA 7 were in the bathroom when LPN 9 entered the room. LPN 9 went to see if Resident Z wanted her foot dressing changed before or after her appointment. LPN 9 heard Resident D mumbling and cussing, going on about not wanting CNA 7 in the room and calling CNA 7 a bitch. CNA 7 was in the room at the time LPN 9 heard Resident D mumbling and cussing, as CNA 7 was assisting Resident Z with getting dressed. Resident D's voice was raised, but she wasn't yelling. LPN 9 motioned for UM 8 to come into the room. UM 8 could hear what Resident D was saying and LPN 9 informed UM 8 that Resident D did not want CNA 7 to work with her, because she'd worked with her before. The only thing LPN 9 heard CNA 7 say to Resident D was that she'd never worked with her before. If LPN 9 hadn't gone down to check on Resident Z's foot, she wouldn't have known that anything was going on. The ED provided the 4/16/25 statement from Resident Z, written and conducted by SSD 10, on 4/16/25 at 12:40 p.m. It read, "Yesterday, [name of CNA 7] the CNA came in our room to get us up for our appointments. While she was taking care of [name of Resident D,] [name of Resident D] became mad, and called [name of CNA 7] a 'B**** and to f*** off.' [Name of CNA 7] snapped back, 'Don't call me a b****, that's not right, I am just			

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	trying to care for you.'" The statement was signed by Resident Z. The statement did not indicate Resident Z heard CNA 7 call Resident D a b****, as she indicated in the above 4/16/25, 10:36 a.m. interview. On 4/16/25 at 12:45 p.m., an interview was conducted with Resident Z in another resident's room, while the other resident waited outside of the open door. She indicated CNA 7 did call Resident D a b****, and that CNA 7 had the right to defend herself. SSD 10 came and spoke with Resident Z about the incident, but SSD 10 did not ask her if CNA 7 called Resident D a b****, so that part wasn't in her statement. Resident Z requested UM 8 be asked to assist her to SSD 10's office to clarify with SSD 10 what happened yesterday between CNA 7 and Resident D. An observation of an interview conducted by SSD 10 with Resident Z was made on 4/16/25 at 12:49 p.m. SSD 10 requested clarification from Resident Z regarding her signed interview from earlier. Resident Z informed SSD 10 that "[Name of CNA 7] did call her a bitch," but that was only in retaliation, as Resident D was refusing to get up, and Resident D first called CNA 7 a b****, and to get the f*** out of her room. "CNA 7 was just trying to do her job. ...The reason [name of LPN 9] came down to our room is because she heard the screaming match. 'You ain't gonna call me a b****, b****. I'm just tryna [sic] take care of you.'" During the interview, SSD 10 retyped Resident Z's statement and had her sign it afterwards. Resident Z took the statement from SSD 10 and immediately signed it. The ED provided a copy of Resident Z's revised statement on 4/16/25 at 1:10 p.m. It read, "Yesterday, [name of CNA 7] the CNA came in			

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	our room to get us up for our appointments. While she was taking care of [name of Resident D,] [name of Resident D] became mad, and called [name of CNA 7] a 'B**** and to f*** off.' [Name of CNA 7] snapped back, 'Don't call me a b****, that's not right, I am jut tring [sic] to take care of you.' Then [Name of CNA 7] did say, 'You ain't going to call me no b****, b****, I am just trying to take care of you.' [Name of Resident D] said, 'Get the f*** out of my room.' [Name of Resident D] has done that before. The other CNA came in, when things had quieted down some. [Name of CNA 7] did not provide care to [name of Resident D] for the rest of the day." The ED provided a copy of Qualified Medication Aide (QMA) 12's typed and signed statement, dated 4/17/25, via e-mail on 4/22/25 at 12:02 p.m. The statement indicated the following, "I [QMA 12] was at the nurses station charting. I started hearing something from that direction- I asked [name of LPN 9] to go check on them- I heard [name of CNA 7] say, 'don't call me a b****, don't talk to me like that. I didn't come in here and call you out of your name.' I didn't hear [name of CNA 7] call her [Resident D] a name, just said, 'don't call me a b****.' Once [name of UM 8] came in she had [CNA 7] leave and swapped out that room- so I took those 2 residents [Resident D and Resident Z]. [Name of Resident D] didn't tell me [QMA 12] [CNA 7] called her a b****- but she didn't want her [CNA 7] back in the room and said she [Resident D] was happy [QMA 12] was there helping her...." A copy of the facility's floor plan was reviewed and indicated the nurse's station was in the center of the unit where Resident D and Resident Z reside and included a total of three hallways with resident rooms. Resident D and Resident Z's room			

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	was located down the hallway East of the nurse's station and was the last room at the end of the hallway. The Abuse & Neglect & Misappropriation of Property policy was provided by the Administrator on 4/16/25 at 12:40 p.m. It indicated, "Verbal Abuse: In Indiana, oral, written, and/or gestured language that includes disparaging and/or derogatory terms to the residents or their families either directly or within their hearing. This may include resident to resident verbal threats of harm but excludes random statements of a cognitively impaired resident such as repetitive name calling or nonsensical language. Verbal abuse includes any staff to resident episodes....It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents." This citation relates to Complaint IN00457650. 3.1-27(b)			