STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	155334		C 06/01/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00260632, IN00260883, IN00262618, IN00263262, and IN00263550. Complaint IN00260632- Unsubstantiated due to lack of evidence. Complaint IN00260883- Unsubstantiated due to lack of evidence. Complaint IN00262618- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00263262- Unsubstantiated due to lack of evidence. Complaint IN00263550- Unsubstantiated due to lack of evidence. Survey dates: May 30 and 31, and June 1, 2018 Facility number: 000227 Provider number: 155334 AIM number: 100267520 Census bed type: SNF/NF: 138 Total: 138 Census payor type: Medicare: 12 Medicaid: 98 Other: 28 Total: 138 Wildwood Healthcare Center was found to be in compliance with 42 CFR Part 483, Subpart B and	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	155334		C **06/01/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00260632, IN00260883, IN00262618, IN00263262, and IN00263550. Quality review completed on June 4, 2018.	F 000		