

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Wildwood Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7301 E 16th St Indianapolis, IN 46219	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to provide adequate supervision during nightly smoking activities. This had a potential to effect 74 of 74 residents that participate in the smoke activity. (Residents' M, N, R, T, NN, PP, C, DD, EE and L)Findings include:1.The clinical record for Resident M was reviewed on 7/29/26 at 9:15 a.m. The diagnoses included but were not limited to: heart failure (heart unable to pump blood sufficiently). A quarterly 5/15/26 Minimum Data Set (MDS) Assessment indicated Resident M was cognitively intact. A smoking assessment, dated 6/23/26, indicated Resident M smokes cigarettes. The assessment indicated the resident was to wear a fire resistant apron, and staff supervision was to be provided during his smoking activity. An observation was made of a smoking activity in the courtyard on 7/28/26 at 10:15 p.m. Resident M was observed smoking outside on the courtyard porch with no apron on and there were no staff present outside. An interview was conducted with Resident M on 7/28/26 at 10:25 p.m. He indicated he had not ever seen staff come out at night to monitor the residents' smoking in the courtyard. 2. An interview was conducted with Resident N on 7/28/26 at 2:00 p.m. She indicated residents can go outside in the courtyard all night if they want to smoke. At night, some residents do sit out in the courtyard smoking and drinking alcohol. An interview was conducted with Resident R on 7/28/26 at 2:30 p.m. She indicated residents are outside in the courtyard drinking alcohol at night. An interview was conducted with Resident T on 7/28/26 at 2:40 p.m. She indicated the staff do not come outside at night in the courtyard. She has drunk alcohol while in the courtyard outside smoking. During an observation of a smoking activity in the courtyard on 7/28/26 at 10:20 p.m., the gazebo and surrounding area were observed. The area was dark with minimal lighting making it difficult to observe the residents in that area. Six residents were observed in the gazebo area and 4 residents on the courtyard porch participating in a smoking activity. There were no staff present outside in the courtyard. During that time, interviews were conducted with the residents in the gazebo area. Resident NN indicated the smoking aides at night do not come outside. The smoking aides do at times sit in the game room to observe the residents that smoke, but they have at times been found sleeping in the game room. Resident PP indicated staff do not come out in the courtyard at night while the residents were smoking. At 3:00 a.m. it's a party out here. Interviews were conducted with Resident C, Resident DD, Resident EE on 7/28/26 at 10:25 p.m. They indicated staff are not outside in the courtyard at night to watch the residents' smoke. Resident C indicated, He has gotten drunk and passed out in the courtyard. He stated, We are fine out here. We don't need staff out here watching us. An interview was conducted with Smoking Aide 6 on 7/28/26 at 10:26 p.m. She indicated she works from 3:00 p.m. to 11:00 p.m. After 11:00 p.m., the nurses know which residents go out to smoke at night, so they check on them in the courtyard. An interview was conducted with Certified Nursing Assistant (CNA) 5 on 7/29/26 at 10:00 a.m. She indicated there were no smoking aides on night shift. (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There were residents that do go out and smoke at night in the courtyard. An interview was conducted with CNA 4 on 7/29/26 at 11:13 a.m. She indicated the residents do sneak and drink alcohol in the courtyard. At times, residents are intoxicated and exhibit behaviors. The staff, when made aware of will confiscate the alcohol if observed on the residents. An interview was conducted with Resident L on 7/29/26 at 1:50 p.m. He indicated at night the staff were unable to observe what goes on in the gazebo in the courtyard. The residents were outside drinking and smoking. Some residents did get drunk. An interview was conducted with Smoking Aide 3 on 7/29/26 at 2:32 p.m. She indicated she was the smoking aide on day shift. The hours are 7:00 a.m. to 3:00 p.m. She had not observed any residents drinking alcohol in the courtyard but had heard residents have done it. A smoking policy was provided by the Executive Director on 7/28/26 at 11:14 a.m. It indicated, .It is the policy of this facility to promote resident centered care by providing a safe smoking area for residents that request to smoke and are capable of safe smoking behaviors either independently or with supervision.Procedure: 9. Smoking safety instructions for all smokers will include. Supervised smoking will be performed by a staff member. This citation is related to Intakes 3095772 and 3107656.Indiana Administrative Code 16.2-3.1-45(a)(2)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse by a resident-to-resident altercation for 1 of 6 residents reviewed for abuse. (Residents' L and K) Findings include: 1. The clinical record for Resident L was reviewed on 7/29/26 at 2:15 p.m. The diagnoses included but were not limited to: anxiety disorder. A Quarterly 5/22/26, MDS Assessment indicated Resident L was cognitively intact. A behavior care plan for Resident L, dated 7/21/26, indicated the resident exhibits anger outbursts towards others. 2. The clinical record for Resident K was reviewed on 7/29/26 at 2:00 p.m. The diagnoses included but were not limited to: Paranoid Schizophrenia (mental illness, that exhibits behaviors of delusions, hallucinations, and suspicion), anxiety disorder (mental illness that exhibits excessive worry or fear), and depressive disorder (mental state of feeling of sad). A Quarterly Minimum Data Set (MDS) Assessment, dated 6/23/26, indicated Resident K was cognitively intact. A Paranoid Schizophrenia care plan, dated 10/7/25, indicated the resident had a behavior of agitation. A nursing note for Resident K, dated 7/22/26, indicated, Resident [K] was coming inside from smoking and male peer [Resident L] was going outside to smoke. Male peer allegedly made a comment and the two [Resident K and Resident L] exchanged words. Resident [K] is alleging that male peer hit her across the arm. Residents were separated immediately. A reportable incident to the Indiana Department of Health, indicated on 7/22/26 at 2:01 p.m., Resident K alleged to have had a verbal argument and hit in the arm by Resident L coming in from a smoking activity. Both residents were immediately separated. Resident L was placed on one-on-one staff supervision, and an investigation was initiated of the incident. The Executive Director provided the on-going investigation between Resident K and Resident L on 7/29/26 at 2:00 p.m. It included, but not limited to the following documents: A statement by Resident K, dated 7/24/26, indicated, I was going out to smoke from the dining room and [Resident L] said stay out of my room tell [another female resident] to stay out of the [another male resident's name] room. He called me a b**** and grabbed me around the throat and picked me up and put me against the wall and wouldn't let go until a staff member stopped him, he also threw my buggy [a device to hold onto while walking to help with stabilization] down in the process. A statement by Resident L, dated 7/24/26, indicated, I was going towards the smoking area, and [Resident K] was coming in from smoking. I asked her to please stay the f*** out of my room. She said F*** you and I got mad and turned her buggy over she then turned mine over and I pushed her and staff came and broke it up. A statement by Smoking Aide 3, dated 7/28/26, indicated, I came out into the hallway and saw [Resident L] knock over [Resident K]'s rollator [buggy] over and then [Resident K] went and knocked [Resident L]'s rollator over and that was then [Resident L] reached out and appeared to push [Resident K]. I got them separated and [Resident L] went outside and [Resident K] walked towards the front lobby. An interview was conducted with Resident K on 7/29/26 at 2:04 p.m. She indicated she did not get along with Resident L. Resident K earlier in the day, had been in Resident L's room visiting Resident L's roommate. Later, Resident K was coming in from a smoking activity while Resident L had passed her going to the smoking activity. At that time, Resident L told her to stay out of his room and called her a b****. They both began to verbally exchange words, and he threw her buggy. After, he grabbed her by the throat and pushed her up against the wall. A staff person had come to her aid and separated them. Resident K indicated she was scared. An interview was conducted with Smoking Aide 3 on 7/29/26 at 2:32 p.m. She indicated in the hallway to exit the facility into a courtyard to attend a smoking activity; she observed a resident-to-resident altercation (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	between Resident L and Resident K. Resident L had pinned Resident K up against the wall with his hands at her neck area with her shirt bunched up in his hands. Both residents were yelling and cussing back-in-forth at each other. There was no barrier between the two residents. Both Resident L and Resident K's rollators (buggies) were turned over. An abuse policy was provided by the Executive Director on 7/29/26 at 11:14 a.m. It indicated, Policy: 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. It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and/or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property. This citation is related to Intakes 3095772 and 3107656. Indiana Administrative Code 16.2-3.1-27(a)(1)		