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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wildwood Healthcare Center	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure foods were served in a sanitary and safe manner for 3 of 3 observations. Staff hair was not covered while in the kitchen, food preparation, and serving areas. (Dietary Manager, [NAME] 2, Dietary Aide 3) Findings include: 1. During the initial kitchen tour with the Dietary Manager (DM) on 1/5/26 from 9:10 a.m. to 9:35 a.m., the following was observed: - The DM was observed walking throughout the kitchen area. The DM was observed to have a beard restraint in place that covered above the nose area, below the chin area and approximately 2 inches from the ears. Facial hair, approximately one-fourth inch in length, was observed between the ears and the edge of the beard guard. The facial hair was observed to not be covered. - Dietary Aide 3 was observed walking throughout the kitchen area. Dietary Aide 3 was observed to have facial hair approximately one-fourth inch in length above the upper lip area. The facial hair was observed to not be covered. 2. During a follow-up kitchen observation on 1/5/26 from 11:55 a.m. to 12:02 p.m., the following was observed: - The DM was observed working at the steamtable, which held the noon meal foods, and was taking the starting food temperatures. The DM was observed to have a beard restraint in place under the chin area. Facial hair above and below the lips, between the jaw line and the upper cheek area, and in front of the ears was observed to not be covered. The uncovered hair ranged in length from one-fourth inch in length to 1 inch in length. - Dietary Aide 3 was observed walking throughout the kitchen area near the steamtable which held the noon meal foods. Dietary Aide 3 was observed to have facial hair approximately one-fourth inch in length above the upper lip area. The facial hair was observed to not be covered. 3. During a subsequent kitchen observation on 1/5/26 from 1:05 p.m. to 1:10 p.m., the following was observed: - The DM was observed walking throughout the kitchen area and working at the steamtable that held the noon meal foods. The DM was observed to have a beard restraint in place that covered above the nose area, below the chin area and approximately 2 inches from the ears. Facial hair, approximately one-fourth inch in length, was observed between the ears and the edge of the beard guard. The facial hair was observed to not be covered. - Dietary Aide 3 was observed walking throughout the kitchen area near the steamtable which held the noon meal foods and was pushing the drink cart from the kitchen to the dining room area. Dietary Aide 3 was observed to have facial hair approximately one-fourth inch in length above the upper lip area. The facial hair was observed to not be covered. - [NAME] 2 was observed working at the steamtable plating the resident's noon meal and was taking the ending food temperatures. [NAME] 2 was observed to have a hair net that covered the hair approximately 2 inches above the ears to the top of his head. [NAME] 2's hair, approximately one-half inch in length, located below the hair net near the ears and down to the neckline, was observed to not be covered. During an interview on 1/5/26 at 1:15 p.m., the DM indicated that hair was to be kept covered while in the kitchen area. On 1/5/26 at 1:33 p.m., the DM provided a copy of the Staff Attire policy, dated January 2025, and indicated it was the current policy in use by the facility. A review of the policy indicated, .All staff will have their hair.confined in a hair net or cap.facial hair properly restrained. On 1/5/26 at 3:30 p.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC 7-26, effective April 16, 2025, indicated, .food employees shall wear hair (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	restraints, such as hats, hair coverings or nets, beard restraints .that are designed and worn to effectively keep their hair from contacting .exposed food . 3.1-21(i)(2)3.1-21(i)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation and interview, the facility failed to ensure private information was kept confidential for 29 of 127 residents that reside in the facility for 3 of 5 days of the survey. (Resident 1, Resident 4, Resident 5, Resident 7, Resident 10, Resident 11, Resident 15, Resident 20, Resident 22, Resident 26, Resident 25, Resident 35, Resident 43, Resident 44, Resident 46, Resident 53, Resident 64, Resident 82, Resident 83, Resident 84, Resident 93, Resident 103, Resident 106, Resident 107, Resident 108, Resident 110, Resident 141, Resident 142, Resident 143)Findings include: On 1/5/26 at 9:35 a.m., white dry erase boards located across from the 400 and 500 hallways' nursing station were observed. The whiteboards, visible to all visitors and other residents, indicated the following resident information by each resident's room number. The specific resident room numbers were listed under the following categories, including but not limited to: -Daily Showers, Day [Showers]: (Resident's specific room number) Resident 93(Resident's specific room number) Resident 11(Resident's specific room number) Resident 46(Resident's specific room number) Resident 22(Resident's specific room number) Resident 20(Resident's specific room number) Resident 82 -Daily Showers, Evening [Showers]: (Resident's specific room number) Resident 108(Resident's specific room number) Resident 1(Resident's specific room number) Resident 26 -Daily Weights: (Resident's specific room number) Resident 11(Resident's specific room number) Resident 15(Resident's specific room number) Resident 107(Resident's specific room number) Resident 46(Resident's specific room number) Resident 142(Resident's specific room number) Resident 35 -Catheter Care: (Resident's specific room number) Resident 1 -Ostomy: (Resident's specific room number) Resident 1(Resident's specific room number) Resident 108 On 1/6/26 at 8:55 a.m., a white dry erase board located across from the 700 hallway's nursing station by the unit manager's office was observed. The whiteboard, visible to all visitors and other residents, indicated the following resident information by each resident's room number. The specific resident room numbers were listed under the following categories, including but not limited to: -Daily Weights: (Resident's specific room number) Resident 7(Resident's specific room number) Resident 10(Resident's specific room number) Resident 25(Resident's specific room number) Resident 43(Resident's specific room number) Resident 83 -Cath [Catheter] O/P (Cather Output): (Resident's specific room number) Resident 106(Resident's specific room number) Resident 7(Resident's specific room number) Resident 10(Resident's specific room number) Resident 64 Resident 106, Resident 7, and Resident 10 had output numbers next to their room numbers and Resident 64 said self indicating they performed their own catheter care. On 1/7/26 at 1:35 p.m., white dry erase boards located across from the 400 and 500 hallways' nursing station were observed. The whiteboards, visible to all visitors and other residents, indicated the following resident information by each resident's room number. The specific resident room numbers were listed under the following categories, including but not limited to: -Daily Showers, Day [Showers]: (Resident's specific room number) Resident 107(Resident's specific room number) Resident 20(Resident's specific room number) Resident 35(Resident's specific room number) Resident 53(Resident's specific room number) Resident 103(Resident's specific room number) Resident 110(Resident's specific room number) Resident 44(Resident's specific room number) Resident 141(Resident's specific room number) Resident 143 -Daily Showers, Evening [Showers]: (Resident's specific room number) Resident 108(Resident's specific room number) Resident 1(Resident's specific room number) Resident 26(Resident's specific room number) Resident 84(Resident's specific room number) Resident 82 -Daily Weights: (Resident's specific room number) Resident 110(Resident's specific room number) Resident 4(Resident's specific room number) Resident 11 -Catheter Care: (Resident's specific room number) Resident 1 -Ostomy: (Resident's specific room number) Resident 1(Resident's specific room number) Resident 108 On 1/7/26 at 1:40 p.m., a white dry erase board located across from the 700 hallway's nursing station by the unit manager's office was observed. The whiteboard, visible to all visitors and other residents, indicated the following resident information by (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	each resident's room number. The specific resident room numbers were listed under the following categories, including but not limited to: -Daily Weights: (Resident's specific room number) Resident 7(Resident's specific room number) Resident 83 -Cath [Catheter] O/P (Cather Output): (Resident's specific room number) Resident 106(Resident's specific room number) Resident 7(Resident's specific room number) Resident 10(Resident's specific room number) Resident 64 -Shower/Bed Baths: (Resident's specific room number) Resident 106(Resident's specific room number) Resident 10(Resident's specific room number) Resident 64(Resident's specific room number) Resident 5 During an interview on 1/8/26 at 11:20 a.m., the DON (Director of Nursing) and the RNC (Regional Nurse Consultant) indicated that the facility lacked a policy related to the privacy or confidentiality of resident personal or medical information, but that such information should not be visible to other residents or visitors. During an interview on 1/8/26 at 11:35 a.m., the Administrator indicated that the facility lacked a policy related to the privacy or confidentiality of resident personal or medical information, but that such information should not be visible to other residents or visitors. 3.1-3(o)