

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND<br>PLAN OF CORRECTIONS                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                            |                                  | (X2) MULTIPLE<br>CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING |  | (X3) DATE SURVEY<br>COMPLETED<br><br>09/18/2025 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>HARRISON AT EAGLE VALLEY, THE                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP<br>CODE<br><br>3060 VALLEY FARMS ROAD,<br>INDIANAPOLIS, , 46214 |                                  |                                                                 |  |                                                 |  |
| (X4) ID<br>PREFIX TAG                                                                                                                                                                                                                             | SUMMARY STATEMENT OF<br>DEFICIENCIES...                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION... |                                                                 |  | (X5)<br>COMPLETION<br>DATE                      |  |
| R 0000                                                                                                                                                                                                                                            | <p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Intake IN00464831.</p> <p>Intake IN00464831- No deficiencies related to the allegations are cited.</p> <p>Survey date: September 18, 2025</p> <p>Facility number: 014045</p> <p>Residential Census: 91</p> <p>The Harrison at Eagle Valley was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Intake IN00464831.</p> <p>Quality review completed on September 26, 2025.</p> | R 0000                                                                                           |                                  |                                                                 |  |                                                 |  |
| Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                                  |                                                                 |  |                                                 |  |
| LABORATORY DIRECTOR'S OR<br>PROVIDER/SUPPLIER REPRESENTATIVE'S<br>SIGNATURE                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  | TITLE                            |                                                                 |  | (X6) DATE                                       |  |