

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER HARRISON AT EAGLE VALLEY, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 3060 VALLEY FARMS ROAD, INDIANAPOLIS, , 46214					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Intake 469487. Intake 469487 - No deficiencies related to the allegations are cited. Survey dates: June 9 and 10, 2026 Facility number: 014045 Residential Census: 85 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 19, 2026.	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 PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE			(X6) DATE	