

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 08/23/2024	
NAME OF PROVIDER OR SUPPLIER FORT HARRISON ALF OPERATIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 8025 DOUBLEDAY DRIVE, INDIANAPOLIS, , 46216					
(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 the Investigation of Complaints IN00440489, IN00440634, and IN00441479. Complaint IN00440489 -- No deficiencies related to the allegations are cited. Complaint IN00440634 -- No deficiencies related to the allegations are cited. Complaint IN00441479 -- No deficiencies related to the allegations are cited. Survey dates: August 22 and 23, 2024 Facility number: 014109 Residential Census: 53 Fort Harrison ALF Operations was found to be in compliance with 410 IAC 16.2-5 in regards to the Investigation of Complaints IN00440489, IN00440634, and IN00441479.	R 0000					

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

FORM APPROVED

OMB NO. 0938-0391

	Quality review completed on August 26, 2024.			
--	---	--	--	--

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
---	-------	-----------