

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE &amp; MEDICAID SERVICES

OMB NO. 0938-0391

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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>05/01/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>FORT HARRISON ALF OPERATIONS                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP<br>CODE<br><br>8025 DOUBLEDAY DRIVE,<br>INDIANAPOLIS, , 46216 |                                  |                                                                 |                                                 |
| (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<br/>Investigation of Complaint<br/>IN00458074.</p> <p>Complaint IN00458074 - No<br/>deficiencies related to the<br/>allegations are cited.</p> <p>Survey date: May 1, 2025</p> <p>Facility number: 014109</p> <p>Residential Census: 50</p> <p>Fort Harrison Alf Operations<br/>was found to be in compliance<br/>with 410 IAC 16.2-5 in regard to<br/>the Investigation of Complaint<br/>IN00458074.</p> <p>Quality review completed on<br/>May 6, 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                                                       |                                                 |