STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORT HARRISON ALF OPERATIONS	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 a Post Survey Revisit (PSR) to Investigation of Complaint IN00434051 completed on May 30, 2024. Complaint IN00434051-Corrected Survey dates: July 17, 2024 Facility number: 014109 Residential Census: 55 Fort Harrison Alf Operations was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00434051. Quality review completed on July 18, 2024. This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00434051 completed on May 30, 2024. Complaint IN00434051-Corrected	R 0000		

	Survey dates: July 17, 2024 Facility number: 014109 Residential Census: 55 Fort Harrison Alf Operations was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00434051. Quality review completed on July 18, 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