STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154057	A. BUILDING _____ B. WING _____	C 11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIONS BEHAVIORAL HEALTH SYSTEM	**5602 CAITO DRIVE INDIANAPOLIS, IN 46226**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS This visit was for the investigation of a Federal hospital complaint. Complaint Number: IN00420418 - No deficiencies related to the allegations are cited. Survey Date: 11/3/23 Facility Number: 012773 Options Behavioral Health System is in compliance with 42 CFR 482.43, Discharge Planning, Medicare Conditions of participation, in regard to the investigation of complaint IN00420418. QA: 11/15/23	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE