

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 014109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/01/2025
NAME OF PROVIDER OR SUPPLIER FORT HARRISON ALF OPERATIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216		
(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) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00458074.</p> <p>Complaint IN00458074 - No deficiencies related to the 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 was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00458074.</p> <p>Quality review completed on May 6, 2025.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE