STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREEK OF WASHINGTON	297 SOUTH 100 EAST, WASHINGTON, , 47501

(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 Intake IN00465776. Intake IN00465776: No deficiencies related to the allegation(s) are cited. Survey dates: November 6, 2025 Facility number: 004904 Census Bed Type: Residential: 17 Total: 17 Census Payor Type: Medicaid:1 Other: 16 Total: 17 Cedar Creek of Washington was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard	R 0000		

	to the investigation of Intake IN00465776. Quality review completed on November 7, 2025.			

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