

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/27/2023	
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK OF WASHINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 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 a Investigation of Complaint IN00401567 Survey. Complaint IN00401567- Unsubstantated due to lack of evidence. Survey dates: February 27, 2023 Facility number: 004904 Residential Census: 32 Emerald Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00401567 Survey. Quality review completed on February 28, 2023.	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 PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE			(X6) DATE	