

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 10/29/2025	
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 the Investigation of Intake IN00465589. This visit was in conjunction with a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on October 6, 2025. Intake IN00465589 - No deficiencies related to the allegations are cited. Survey date: October 28 and 29, 2025 Facility number: 0004904 Residential Census: 17 Cedar Creek of Washington was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Intake IN00465589. Quality review completed October 30, 2025.	R 0000					

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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