Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004904	A. BUILDING: ______ B. WING ______	C **01/11/2024**

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

(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	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00425010. This visit was in conjunction with a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 10/25/23. Complaint IN00425010 - No deficiencies related to the allegations are cited. Survey date: January 10, 11, 2024 Facility number: 004904 Residential Census: 27 Cedar Creek of Washington was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00425010. Quality review completed on January 12, 2024.	R 000		

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE