

Illinois Department of Public Health

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|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>SHF520127 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY COMPLETED<br><br>C<br>10/04/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>COUNTRY COMFORT HENRY |                                                                                                                                                                                                                                                                   |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>615 PATRICIA LN<br>HENRY, IL 61537                                              |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                      | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| A 000                                                     | Initial Comment<br><br>Facility Reported Incident IL178460<br><br>For this survey, the establishment is in compliance with Part 295 Assisted Living and Shared Housing Establishment Administrative Code and 210 ILCS 9/1 Assisted Living and Shared Housing Act. | A 000                                                               |                                                                                                                          |                          |                                                   |

Illinois Department of Public Health  
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE