

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/28/2025
NAME OF PROVIDER OR SUPPLIER CEDARHURST OF GODFRY		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 AIRPORT RD GODFREY, IL 62035		
(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
A 000	Initial Comment Facility Reported Incident of 11.25.24 / IL184758. Allegations cannot be substantiated. No violations cited. 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 Shored Housing Act.	A 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE