

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510289	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/15/2025
NAME OF PROVIDER OR SUPPLIER REFLECTIONS MEMORY CARE - HERRIN		STREET ADDRESS, CITY, STATE, ZIP CODE 517 RUSHING DRIVE CARTERVILLE, IL 62918		
(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 The Complaint Survey COI #2553762 / IL191192 & the Facility Reported Incident of 04/26/25 / IL191652 were completed together. Complaint :#2553762 / IL191192 Allegations cannot be substantiated. No violations cited. Facility Report Incident Investigation to Incident of 04/26/25 / IL191652. 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 Shared Housing Act.	A 000		

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

TITLE

(X6) DATE