

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2025
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NAME OF PROVIDER OR SUPPLIER CEDARHURST OF HIGHLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 220 FIELD CROSSING DR HIGHLAND, IL 62249
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(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
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A 000	<p>Initial Comment</p> <p>Annual State Licensure Survey</p> <p>Cedarhurst of Highland is in general compliance with the requirements of the Assisted Living and Shared Housing Establishment Code for this survey</p>	A 000		
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If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE