STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510550	A. BUILDING: _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY ESTATES MEMORY CARE	510 E JACKSON ST PANA, IL 62557

(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 Annual survey and the Facility Reported Incident of 03/22/25 were completed together. Facility Reported Incident of 03/22/25 /IL189121. No violations. Annual Survey No violations. For this survey, the establishment is in compliance with Part 295 Assisted Living and Shared Housing Establishment Administrative Code and 210 ICS 9/1 Assisted Living and Shored Housing Act.	A 000		