

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510413	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/21/2025
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NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF MORRISON	STREET ADDRESS, CITY, STATE, ZIP CODE 403 SCENIC STREET MORRISON, IL 61270
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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
A 000	<p>Initial Comment</p> <p>Facility Reported Incident of 8/2/25/ IL 196746</p> <p>For this survey, the establishment is in compliance with Part 295 Assisted Living and Shared housing Establishment Administrative Code and 210 ILCS9/1 Assisted Living and Shared Housing Act.</p>	A 000		

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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