

Illinois Department of Public Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>ASL510343</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>01/22/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNRISE OF BLOOMINGDALE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>129 E LAKE ST</b><br><b>BLOOMINGDALE, IL 60108</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| A 000                                                              | <p>Initial Comment</p> <p>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.</p> <p>Complaint Investigation<br/>IL172489/247333-Substantiated, no deficiency cited.</p> <p>Entity Reported Incident Investigation<br/>IL182158-Substantiated, no deficiency cited.<br/>IL176260-Substantiated, no deficiency cited.<br/>IL175844-Substantiated, no deficiency cited.<br/>IL174735-Substantiated, no deficiency cited.</p> | A 000                                                                                          |                                                                                                                          |                                                                    |

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

TITLE

(X6) DATE