

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL5106197	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/20/2025
NAME OF PROVIDER OR SUPPLIER EMERALD PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1879 CHESTNUT AVE GLENVIEW, IL 60025		
(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 Compliant Investigation IL00186424 Refer to complaint with exit date of 2/3/25 and correction date of 2/28/25, IL180059/2498878, IL00183523/2580044 in which R1, R5(subjects of IL00186424) were reviewed for staffing with substantiated violation at 295.3000 a) for short staffing.	A 000			

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE