

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>ASL510100</b>                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>02/28/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADDINGTON PLACE OF COLLINSVILLE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1207 VANDALIA AVENUE</b><br><b>COLLINSVILLE, IL 62234</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>The Complaint Surveys; COI# 2541632 / IL187205, COI# 2541513 / IL187003, COI3 2541633 / IL187212, &amp; COI# 2541634 / IL197212 were all completed together.</p> <p>Complaint: COI# 2541632 / IL187205, COI# 2541513 / IL187003, COI3 2541633 / IL187212, &amp; COI# 2541634 / IL197212 were all completed together.</p> <p>Allegations cannot be substantiated. No violations cited.</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 Shored Housing Act.</p> | A 000                                                                                                 |                                                                                                                          |                                                                    |

Illinois Department of Public Health

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

TITLE

(X6) DATE