

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ASL510347</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/04/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>SUNRISE OF FOUNTAIN SQUARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2210 FOUNTAIN SQUARE</b> <b>LOMBARD, IL 60148</b>		
(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  Facility Reported Incident Investigation Conducted: #179671-#181839-#186418 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.	A 000		

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

TITLE

(X6) DATE